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Original Articles.

OBJECT LESSONS IN GYNÆCOLOGY.

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I.

THE GALL-STONE DIAGNOSIS.

Pelvic inflammatory conditions simulate so many and so various forms of disease, that the general practitioner may well be pardoned who fails to attribute to their proper cause the myriad symptoms arising from even the grossest pelvic lesions. One of the most striking and misleading symptoms due to well-marked disease of the appendages, is a severe, agonizing and sickening pain, radiating across the epigastrium, and locating with great intensity in the region of the gall-bladder. The patient sits up in bed, leans forward, grasps the region of the gall-bladder and stomach with both hands, and retches as though she would throw up her immortal soul. What makes this symptom more misleading, is the mild jaundice which often follows, with coated tongue, loss of appetite, and marked tenderness on pressure over the locality of the gall-bladder. When the practitioner, for the first time sees the patient in one of these paroxysms, his attention is so forcibly called to the liver as the *fons et origo* of the trouble, that he is very prone to stop at that organ, and interrogate no other anatomical structure for information. A diagnosis of gall-stone colic is promptly made, and, knowing the futility of medicine for permanent relief or curative action on such a pathological condition, he confidently reaches for his hypodermic syringe and promises immediate relief. Here another surprise awaits him. Heretofore various attacks of abdominal pain, such as spasmodic colic or cholera morbus, or simple gastralgia due to

acute indigestion, have, in his hands, yielded promptly to a single injection of an eighth or a sixteenth of a grain of morphia; but in this case the patient receives from one-half to three-fourths, or even a grain, ere she can be quieted, and even then her rest is only fitful, and the morphia must be repeated every 4 or 5 hours, often for days, before the attack subsides, which happens whenever the pelvic congestion, due to a menstrual mola, passes away under the influence of the pain-enforced rest, the lightly injected food, a consequence of the anorexia of disease, and the free purgation inaugurated to overcome the constipation resulting from the large quantity of morphia necessary to subdue the imaginary gall-stone cramps.

This is a symptom which is, in my experience, most often found associated with a large, adherent tubo-ovarian cyst of one side, filled with sanguino-purulent material and lying high up, while the tube of the other side is highly inflamed and contains a small collection of pus, with an adherent, atrophied and cirrhotic ovary at its fimbriated and occluded extremity. There are certain precautions to be observed when we are called to such a case that will always prevent us from falling into error. First, when called to see a woman suffering from any severe or obscure form of abdominal pain, suspect the pelvis, and proceed to interrogate it. In these cases where gall-stones are suspected, if the disease is located within the pelvis, a great many other symptoms may be elicited by judicious questioning, which ought to pave the way for a digital examination. The pains and nausea will be found to precede, and become coexistent with, menstruation, which is very irregular as well as painful. A profuse, purulent and offensive leucorrhœa is a constant and disgusting accompaniment. The stomach is irritable and delicate at all

times, while the appetite is capricious. There is marked discomfort, often severe pain upon motion. Going up or down stairs, or running a sewing-machine will frequently bring on an attack of pain or greatly prolong the menstrual flow. Riding in a jolt-wagon, or in a buggy over rough roads, can not be done without great suffering. If the disease is on the left side, there is marked pain in the left iliac region when the bowels move, and this is much increased when defecation follows upon a previous condition of constipation. The bladder may be irritable, compelling the patient to micturate with great frequency and straining, and only a small quantity of urine can be voided at a time. Sexual intercourse is always painful, very seldom gratifying, never fertile, and often utterly impossible. There is frequently a history of previous abortion or abortions, and not seldom a gonorrhœa can be traced to the husband. While we need not be surprised to find that at some previous confinement she had a "bad getting up," or a "very tender belly with fever for a long time and has never been stout since."

Should several or all of these facts be elicited, a careful bimanual examination should follow. If there is leucorrhœa, we will find the size, position, outline, consistence and patulousness of the uterus all to be considered. We shall not be disappointed to find a soft and patulous os, an enlarged and softened body and fundus, with the uterus in a state of chronic retroversion, and fixed in that position by firm adhesions. The fundus may likewise be pushed to that side opposite the disease, thus lying in an oblique position. On account of the contracture of the adhesions, the uterus may be partially prolapsed. The vault on one or both sides may be found full and tender, and, bimanually, (though not always,) a fluctuating tumor the size of a small lemon may be identified on one or both sides, while pushing the uterus toward the fullest and tenderest side with the finger on the cervix, provokes loud complaint from the patient. To elicit fluctuation, or to determine the consistence of any growth filling the vault, is best done by placing one finger in the vagina, pushing it deeply up against the lateral vault, and then placing the other hand on the abdomen, by making deep pressure downward, back-

ward and inward the growth is pushed against the finger in the vault. Then by a gentle palpation with the outside hand held firmly, fluctuation can be recognized by the finger tip held against the vaginal roof. Given such a case, and having satisfied ourselves that pelvic disease exists beyond a doubt, the next question is, what shall we do to relieve our patient? There are two courses open to us, one of which is temporary, palliative, and only to be used to gain time for the second or radical and curative surgical treatment. Saline cathartics, such as mag. sulph., given in small doses, say a teaspoonful every hour till six or eight doses are taken, will afford the quickest and most enduring relief short of any but surgical methods. Hot douches, the application of dry or moist heat over the abdomen, are good measures for the immediate palliation of pain, and to tide the sufferer over the acute attack in order that time may be gained to prepare for the necessary surgical measures that alone can bring permanent relief. Nothing short of a section, with removal of the morbid structures, will prove in the least curative, and the less delay there is in resorting to surgery, the brighter the prognosis, both as regards the final completeness of cure and the length of time necessary for the acquired reflexes to forget their old habits.

The relief which promptly follows a thorough removal of offending organs by abdominal section in these cases, is often as gratifying to the medical attendant as it is surprising to the patient and her friends. The measure of comfort and freedom from pain and suffering that follows at once the necessary surgical work, is most often in an inverse ratio to the delay in the inauguration of such measures. Time always gives an opportunity for tubal leakage, with its resulting circumscribed peritonitis; increases the strength and multiplies the number and extent of adhesions; gives rise to distortion, displacement and degeneration of structures, producing constriction of nerve-trunks and aberration of functions; abolishes normal action in glandular secretion, or excretion favoring excess of the one, paucity of the other, thus converting local into somatic disease by the mechanical effects of pressure, obstruction and displacement, or by the more insidious, but no less baneful effects of long continued irritation on

nerve-ends, results in morbid reflexes, which, though remote and obscure, are none the less destructive to comfort or elusive to diagnosis.

The following illustrates the difficulties of diagnosis met with in such cases as I have attempted in this article to describe:

Was called late one evening to see Mrs. V., who, the attending physician stated, was suffering from an attack of gall-stones. Had been under his care for several months, with recurring attacks of pain and vomiting. Found her drawn up in bed, hands pressed strongly against the right hypochondrium and stomach, and at intervals straining and vomiting with much effort and in great agony. Tongue coated, bowels constipated, temperature elevated, bladder irritable, and she complained of a sickening pain radiating over region pressed on by hands, and especially at a spot marking the location of the gall-bladder. This region was markedly tender on pressure. There was slight jaundice, complete anorexia, puffy skin, swollen eye lids and intense headache. She had just closed a menstrual period. Personal history showed last child 9 years old, miscarriage six years previous, puerperal peritonitis, specific infection by previous husband, marked irregularity of menstruation ever since, great suffering at times, general invalidism. Sexual intercourse absolutely repulsive on account of pain. I suggested a pelvic examination which was acceded to. Examination showed uterus slightly enlarged, retroverted, partially prolapsed, firmly bound down by adhesions, os soft and patulous, profuse leucorrhœa, left vault full, elastic, very tender to the touch, right vault less so, right obliquity of uterus. Pushing uterus toward the left, caused great pain which was referred to locality complained of when first seen, and which increased the efforts to vomit.

Diagnosis: Tubo-ovarian disease. Section suggested as the only means of cure. Another physician having been called into the case, and having carefully examined her, he was inclined to favor the idea of gall-stones. Wishing to be certain, and having a great deal of respect for his opinion, knowing him to be careful and conscientious, I asked one of the leading Western abdominal surgeons to examine her. He at once confirmed my diagnosis, and endorsed my advice as to a section. After preparing her for the operation, I

removed a large tubo-ovarian cyst from the left side, where I found it completely buried in adhesions. It was filled with blood and pus. The tube and ovary on the right were both diseased. The tube dark, highly inflamed, its fimbriated extremity occluded and adherent to the ovary, which was small and cirrhotic. The tube contained a small quantity of pus. Both tube and ovary were bound to omentum and pelvic peritoneum by moderately firm adhesions. She made an uneventful recovery, and has been able to go about and enjoy life ever since the fourth week after the operation. She has continued to grow stronger, and has had no more of her old attacks of pain, although a year has intervened since she underwent the operation.

LIVER INDIGESTION.

By J. D. MYERS, M. D.,

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Recognizing the fact that the tendency of the age is to run after new ideas, frequently losing sight of the old well established landmarks, I wish to recall to the attention of the profession some old but vital truths. I have discovered no new bacilli or bacteria, but have unearthed some important facts which I beg leave to present.

It is not my intention in this paper to make mention of any of the organic diseases or accidents which may affect the liver, but only that functional trouble known as biliousness, or better, liver indigestion, with its sequelæ. In order to fully understand our subject it will be well to say a few words as to the liver and its functions, although it may seem like repeating an old tale. The liver is the largest, and we may say the most important gland in the body, its size and the importance of its functions being considered. In the mature fœtus, it holds one-fourth or more of the entire volume of blood and is larger than both lungs. At birth the weight of the liver is in proportion to the whole body as one to twenty-eight; in infancy one to twenty, at puberty one to thirty, in adult one to thirty-five, in middle life one to forty, and in old age one to forty-five. These figures give us a fair idea of the important part it plays in

the economy of our system. Up to about the year 1860, the liver was really a great "terra incognita" whose principal office seemed to be to eliminate bile which was "excrementitious" and was the natural purgative; although as far back as Galen, certain maladies when the urine was altered in appearance and reaction, were rightfully attributed to the liver and not the kidneys. Dr. Kirke, in his *Physiology* published in 1860, although he had made great advances in the analysis of the composition of bile, and recognized in it the presence of glycocholic and taurocholic acids in union with soda, threw no light upon their origin.

Not till 1874 was the three-fold function of the liver demonstrated, which is as follows:

1st. "The formation of glycogen which contributes to the maintenance of animal heat, to the nutrition of the blood and tissues, and the development of white blood corpuscles.

2d. The destructive metamorphosis of albuminoid matter and the formation of urea and other nitrogenous products which are subsequently eliminated by the kidneys, these chemical inter-changes also contributing to the development of animal heat.

3d. The secretion of bile, the greater part of which is reabsorbed, assisting in the assimilation of fats and peptones, and probably in those chemical changes which go on in the liver and portal circulation; while part is excrementitious and in passing along the bowel stimulates peristalsis and arrests decomposition."

This summary brings us well up to our time, and gives in condensed form the results of years of patient investigation. We recognize then, that the liver is the storehouse for our fuel food in the form of glycogen, which is converted into sugar by a ferment, in the liver itself as the needs of the system demand. Hence, we can readily see how any derangement in this glycogenic function of the liver will give us diabetes mellitus. The disorders of the liver, are, however, mainly connected with its second function, that is, the metabolism of albuminoids; we easily recognize its action in the destruction of waste and excessive albuminoids; we know that urea is formed by the liver and not the kidneys, we find that lithiasis is primarily a derangement of the liver, and that it is waste

matter in the blood which after a time produces structural changes in the kidneys. We can also see that when oxidation is imperfect, it is the nitrogenous matters that suffer.

What we now wish to reach is the further elaboration of the proteid matters which have been converted into peptones in the stomach. There is no doubt that a further elaboration of peptones goes on in the liver and disturbance of this organ leads to mal-nutrition. It seems just here that the liver has another function, that of arresting certain matters whose presence in the blood would be noxious and allowing nutritive matters to pass on.

It has been demonstrated by experiment that peptones when taken into the general circulation are depressants.

Peptones injected into the veins in small quantities prevent the coagulation of the blood, and in larger quantities produce a depression of the circulation, a soporific condition, complete arrest of secretion by the kidneys, convulsions and death. Thus we see the normal products of digestion are poisons, and if they reach the general circulation in large quantities will produce alarming and dangerous symptoms, as a consequence then, of a disturbance in the workings of the liver, we have not only a badly nourished organism, but one actually poisoned by the presence of these products of digestion. We have both anemia and toxæmia. Is it any wonder then, that nervous depression and irritability always accompany this form of indigestion? We find then, to sum up that there is in the healthy liver both a digestive and a filtering process. We may therefore suffer with that form of indigestion called "biliousness," either from imperfect digestion of the food, or imperfect filtration. In either case the system is ill fed and also poisoned by the absence of certain constituents and the presence of others. We have all seen an acute bilious attack follow free indulgence in rich food, especially in children. Even a small piece of cake may be sufficient to upset the digestion followed by nausea, headache, sometimes vomiting (this gives relief) and sometimes purging. Now these are the facts of the case, but what is the cause? The mother will tell you, "it was the sweets and rich cake; anything with too much sugar or butter always upsets that child." The doctor nods

his head and says, "that child must be watched as to its eating and sweets and fatty food must be interdicted." Now this explanation is wrong, for it is the metabolism of albuminoids in the liver which causes this disturbance, and it is the second function of the liver which is involved, that is, the oxidation of waste and nitrogenized matter. The attack is not due so much to the quality as the quantity of the food ingested and is an old-fashioned subject. More food of the kind has been taken than can be assimilated and the surplus must be gotten rid of in some way. Unless removed by vomiting or purging it must be done by oxidation and we are all familiar with the sudden sharp rise of temperature which accompanies acute indigestion. This is simply a bon-fire kindled by the liver to clear out its overloaded store rooms. A mercurial and a saline and the attack is usually over, although the liver may remain irritable, bringing on a condition commonly called "bilious fever." Now this attack was brought on by eating rich food and was ascribed to the butter and sugar, but it was the metabolism of the albuminoids which caused it. The excess of food caused the excess of bile with the consequent general disturbance. The easily oxidizable hydrocarbons were burnt, leaving the albuminoids to be gotten rid of in any way possible. It is therefore the prevention rather than the treatment of such cases that demands our attention. The capacity and strength of each individual liver should be gauged as accurately as possible. Avoid excess in eating, but don't lay too much stress upon any form of food, for so long as the sugar and fat are alone held responsible, so long will the patient be wrongly fed. Albuminoids will be allowed and hydrocarbons interdicted, and the tendency to biliousness directly fostered.

'Tis said, the happiest man in the world is the one who does not know he has a liver, and this reminds me of a trouble we occasionally meet with, but which is not generally recognized. A congenitally inefficient liver. This requires constant watchfulness and care. As it is not up to the work of a normal liver we must reduce the quantity of food to what it can dispose of. However, the largest eaters are not the healthiest or strongest. 'Tis the amount assimilated, and not that ingested that tells the tale. We will now look

briefly at two forms of liver disorder. Biliousness proper, in which the bile acids make the disturbance, and "lithiasis" in which case owing to a derangement of the second function, lithic acid has been formed by the liver. Biliousness is the form of trouble found in persons of "bilious temperament," as it is expressed. They are usually of a dark complexion, with black or dark brown hair, dark eyes with a yellowish tinge of the conjunctiva. They may be active or sluggish, but are possessed of a devil. Appetite capricious, bowels irregular, usually constipated, but have diarrhoea when an attack is passing off. Have frequent and persistent headache, are nervous and irritable and are usually gloomy and morose. The term of Greek derivation, we have adopted for this condition, indicates precisely the cause of this mental depression, "melancholia," which means "black bile." The tongue is usually furred, of a yellowish or brown color and there is a bad taste in the mouth. Sometimes, however, the tongue is clean although the bitter taste is present. Disorder of the bowels is common, there is torpor often accompanied by flatulency, often acidity of the intestines is present, accompanied by a headache peculiarly its own. The stools are pale, more especially so when there are lithates in the urine, and are offensive. Neuralgia, severe headaches, dimness of vision and vertigo are generally present. All these phenomena are those of excess of bile poisoning the whole system, but chiefly disturbing the digestive tract. The influence of this state upon the animal spirits has been long recognized, and is undoubtedly due to the action of the brain and the liver, and to the lowered blood pressure. Mention has already been made of the depression caused by the presence of albuminoids in the blood vessels. While there may be a great deal of "pure cursedness" in the individual, still irritability of temper is a prominent and almost constant companion of the liver trouble. The late Thos. Carlyle, who "had been there," voiced it thus: "The accursed hag, dyspepsia, had got me butted and bridled, and was ever striving to make my living day a thing of ghastly nightmares. I resisted what I could, never did yield or surrender to her, but she kept my heart right heavy, my battle being sore and hopeless." There is really

very little difference in degree of hurtfulness, between the bile acids and the lithi-ates. Both are powerful for evil. We must now, however, look at the remoter results of this perverted liver action and its effects upon other organs. It is but repetition to say that a deposit of lithi-ates in the urine is not due to a morbid condition of the kidneys, but is a sign of functional derangement of the liver, sometimes temporary, sometimes permanent. These lithi-ates are a product of indigestion. The appearance of lithi-ates in the urine during the time the liver is engaged in the digestive process, demonstrates the fact that certain peptones instead of being further elaborated in the liver, have been broken up into lithic acid and lithi-ates. This does not prevent a waste of tissues, but of tissue food as the material which forms this uric acid would under other circumstances have made body tissue. In this same line stands azoturia in which we have an excess of urea. In this we have "excess of urea without diuresis" and excess of urea with diuresis. The first form may be produced by a very slight and almost imperceptible derangement of the assimilative functions, but in the latter, we have the symptoms of a very aggravated form of derangement, accompanied by thirst and morbid craving for food. While this disease is closely allied to diabetes, it is caused by a derangement of the second (not the first) function of the liver. Here we also find "albumin-uria," we all know that the presence of albumin in the urine is usually regarded as a certain evidence of disease of the kidneys, we have been taught how to detect it and know that under certain circumstances its presence is ominous of evil, but we know further, that at other times it means nothing. It has been demonstrated that if two or three raw eggs are eaten at once, albumin appears in the urine. Here more albumin has been ingested than can be digested by a healthy liver, so a part simply passes through the liver and is thrown off by the kidneys. Very often the albuminuria is intermittent, albumin being found in the urine passed at night and not in that voided in the morning; in that passed a short time after eating and not in that secreted fasting. We don't pretend to say the liver is at fault in every such case, but it is so frequently, that it is our duty to carefully interrogate it, and we

find that many cases of albuminuria (?) are cured when the hepatic disorder has been overcome. We find then that crude albumin may pass unchanged into the general circulation and hence through the kidneys, or the metabolism may take place as an excess of urea, or the albuminoids may be split up into lithic acid, generally combined with ammonia or soda. These conditions may be temporary, the result of acute liver indigestion, or become permanent. In the latter case we will have "renal degeneration as a consequence of the long continued elimination. "Nocturnal asthma" is a result of an excess of nitrogenized waste in the blood. This must not be confounded with the asthma caused by an irritation with swelling of the bronchial mucous membrane. It comes on in sleep, especially after a late heavy meal and is caused by the actual presence in the blood vessels of the lungs of the imperfectly digested food. This is especially the case in persons of a gouty diathesis and an attack is easily excited by particular articles of diet or a spell of indigestion.

Disturbance of the heart's action is very common. There is palpitation, but not that form caused by gas in the stomach or transverse colon. In the latter, the gaseous distention presses the diaphragm up against the heart and mechanically interferes with its action. In the former the palpitation is irregular, accompanied by symptoms of mal-assimilation, waste in the blood, high arterial tension and a badly nourished heart. Sometimes the heart's action is depressed and there may be intermissions with or without fluttering.

Angina pectoris is another common trouble with liver dyspeptics and may prove fatal in advanced life when the heart has become impaired by fatty degeneration. Now, this is not a neuralgia of the heart, but is caused by the spasmodic contractions of the small arteries, excited by the excess of nitrogenized waste in the blood. This causes a high blood pressure in the arteries and may produce either palpitation or angina. This arterial spasm is proven by the hands becoming numb (going to sleep) and the feet cold. Irritable bladder is another consequence. Many cases of so-called inflammation of the neck of the bladder, stricture of the urethra, etc., are the direct result of lithi-ates in the blood, due to liver indigestion, and can be cured

by restoring the integrity of the liver. Lithic acid irritates the entire urinary tract like fine sand thrown in the eye. Skin affections are common as a result of this blood poisoning.

Upon no tissue does lithic exert a more irritant influence than upon the brain, and, as before mentioned, a temper is developed. Persons naturally mild and even tempered become irritable and peevish when their blood is thus poisoned. Very often there is chronic insomnia; and after sleep the patient awakes unrefreshed and ready to take offense at nothing. This in brief is a history of the metabolism of albuminoids in the liver, but this condition itself may be a secondary affection produced by derangement of some other organ or function.

Of course, any organic disease of the liver will diminish its digestive and secretive capacity. Disease of the heart, or lungs, by gorging the liver with venous blood may produce this functional disturbance. As has been mentioned the transmutation of the proteids in the liver, assists in the maintenance of animal heat. When the system is in a state of sub-oxidation, the proteids are less able of themselves to generate the heat necessary to complete their nutrition, and instead of tissue food we have lithiates, etc. When the oxygenating process is going on normally in the lungs, this extra supply of heat can be obtained; but when the lungs are diseased the supply of oxygen in the system is diminished, and demands of the liver cannot be complied with, and the second function not being properly performed, we have only impoverished, poisoned blood to nourish and build up an enfeebled body. Suppression of the catamenia and different forms of uterine disease also disturb the workings of the liver. Some of these cases are typical. Dull headache, furred tongue, capricious appetite, constipated bowels, irritable bladders and every symptom of malnutrition. Worry, prolonged mental exercise, or anxiety, not only interfere with the proper secretion of bile, but derange the process of blood-making and oxygenation and induce lithiasis. We are all familiar with these results in the cases of clergymen, students, accountants, etc., who labor with their brains and lead sedentary lives. Before touching upon treatment let me give in a few words the essence of

this paper. When food rich in albuminoids is taken in excess of the needs of the system, the excess is split in the liver and it is the disturbance of this function which causes the production of lithic acid and lithiates. Instead of urea we find the liver producing the feebly oxidized and almost insoluble uric acid. A pernicious habit is thus formed which tends to perpetuate itself. The treatment, and this I can only outline briefly must include not only the immediate trouble, but the possible consequences.

It is not well to resort to mercury as a cholagogue too frequently, as the liver once accustomed to it will not respond to milder stimulants; again, when the kidneys are much impaired the system becomes very intolerant of mercury, and it must be exhibited with great caution. When to give and when to withhold mercury in cases of albuminuria and lithiasis is a question which will frequently puzzle the best physician. In addition to the medicinal treatment is the dietary, and upon it we must lay the greatest stress if we wish to prevent chronic liver indigestion. After what has been said, however, it will not be necessary to go much into detail, if we keep constantly in mind, that alike in biliousness and liver indigestion it is the albuminoids and not the *hydro carbons* which are the *casus belli*. Fruits of all kinds both fresh and cooked are good, provided the stomach which must be consulted first, will tolerate them, and they may be eaten with milk or sugar. The salts in fruit are not in large quantities, but that they are operative, is demonstrative in their antiscorbutic effects. All vegetables, well cooked, except peas and beans, as these contain a large proportion of casein which is albuminoid. Fish is permissible when plainly cooked and served. Oysters in every style except fried. Fowls may be eaten in fair quantities, but we must not forget that they are rich in albuminoids, especially the dark meat. Pork is simply poison, and veal should be eschewed. Beef is good, but mutton is best. Bread is best eaten cold, but there is no necessity for greater detail. As to drinks, will simply say, that alcohol in any shape is, to put it as mildly as possible, very undesirable, it is a powerful hepatic stimulant, and may be permitted under certain circumstances, but in very limited quantities and well diluted. The habitual use, with

seeming impunity of the so-called table wines simply shows how long suffering and forbearing our livers can be, but the day of reckoning will surely come. In conclusion, allow me to call attention to the great mistake we make in the management of these cases. We too frequently mistake the consequence for the cause and direct all our treatment to the symptoms, losing sight of the fact that our great blood-making-machine is skipping cogs; and when a proper diagnosis is made, we do not prosecute our treatment for a sufficient length of time. A few doses or days of treatment give relief, and we then leave the liver debilitated both by the attack and medication to fight its own battles unaided. In all chronic cases the patients should be kept under medicinal treatment for several months and under dietetic for a year or two. Let me illustrate clinically. In 1871 I was sent home from New York to die; my case could not be diagnosed at first, although I know now I had all the symptoms of liver indigestion in its worst form. The attack culminated in an abscess of the liver, which, adhesion having taken place, discharged into the duodenum. It took about twelve months to make the organic repairs, and ten years to overcome the functional disturbance. During the first two years I took medicine regularly three times a day and don't believe I missed half a dozen doses in that time. For ten years I kept up my diuretic treatment, with medicinal aid at irregular intervals. Had I stopped treatment sooner, I would not be, as I now am, perfectly healthy, with the digestion of an ostrich. Then:

Would'st thou live long and well,
Escape the pangs and pains of hell,
And live a life of joy and ease,
'Bove Galen's diet or Hippocrates?
Avoid excess of food and drink,
On the welfare of thy body, think;
Guard well that organ—the life giver,
For he lives not well nor long, who *knows* he has a liver.

FUCH'S COLLYRIUM FOR CHRONIC CONJUNCTIVITIS.

R	Ammonii chloride.....	0.1	gramme.
	Zinci sulphatis.....	0.25	"
	Aque destillate.....	40.0	"
M. et add—			
	Camphore.....	0.08	"
	Dissolved in—		
	Spiritus vini diluentis.....	4.0	"
	Croci.....	0.02	"

Digest for twenty-four hours, stirring frequently. Filter.
Sig.—Eye drops, to be used pure or diluted with equal parts of water.

Communications.

PRINCIPAL RETURNED WITH INTEREST.

P. J. FARNSWORTH, M. D.

CLINTON, IOWA.

Somewhere about the 25th of July ult. a mother held in her hands a five dollar gold piece. She showed it to the little boy of two years and two months who took it quickly and put it in his mouth gave a little gulp and it disappeared.

They consulted the physician at once, who told them not to be apprehensive and repeated the old joke, "If the coin is good it will pass."

They looked for it for two months and then concluded that it was lost. The child's health was good. The mother remembered that he complained of choking occasionally. After breakfast, of bread and milk, October 22d instant, the child gave a little hack or cough and then threw up the five dollars and nothing else.

It had remained in the stomach without inconvenience for three months. There is no doubt of the genuineness of the coin, but instead of "passing" it was "returned."

PERNICIOUS VOMITING OF PREGNANCY.*

By J. G. CECIL, M. D.,

LOUISVILLE, KY.

I have a case to report which is one of considerable interest to me, inasmuch as three or four years ago I read a paper before the Medico-Chirurgical Society of this city, on the subject of pernicious vomiting of pregnancy. At that time I had never seen a fatal case, but since then a fatal case has been reported to that society by Dr. C. Skinner, and I now have one to report myself. The case was one of a young woman perhaps thirty-five years of age, the mother of three children, and in rather delicate health, who became pregnant and almost from the day of her conception, at least as far as she was able to reckon, she commenced to vomit, in spite of any remedy,

*Read before Clinical Society of Louisville, Oct. 4, 1892.

in spite of everything; she went on to her death from the pernicious vomiting of pregnancy—death by starvation. She vomited about eight weeks; I presume from the size of the fœtus pregnancy was not over two and one-half months advanced. I remember at the time I read the paper before the Medico-Chirurgical Society, the position was taken by several of the prominent members of that Society, that inasmuch as these cases were very rare, and, particularly, as they, in their experience, had never met with such a case, under no circumstances (as I remember the trend of their remarks,) would they advocate relief by miscarriage. At that time I tried to defend the position that miscarriage was justifiable, and took the ground that we ought not to go to that extreme, or allow the patient to go to the extreme of the low typhoid condition which precedes death, but after everything else had failed, to induce miscarriage as a last resort, in order to save life. In the case under question, which, by the way, was under the care of another physician, I only having seen the patient on two occasions; once about two weeks before her death, and again the day before death—at the time of my first visit (two weeks prior to her death), her condition was not so serious in my estimation, or in the estimation of my consultant, as to justify miscarriage at that time; in fact, it was not yet ascertained absolutely that she was pregnant. I do not think anyone is able to say positively that a woman is pregnant at two or two and one-half months, but all the evidence pointed to that conclusion. I found that she had a retroverted womb and suspected that she was pregnant, but was not certain. I turned her in the genu-pectoral position and replaced the retroverted womb, endeavoring to hold it in position with a cotton tampon. I advised the doctor to continue this treatment, I was satisfied that the retroversion was the occasion of the persistent vomiting, as is often the case, and in the event that he could not succeed in maintaining the womb in position, then to dilate the cervix with the finger as far as the internal os, but not through it. When I saw the case the second time, the doctor in charge reported that he had not been able to hold the womb in proper position, and had resorted to dilatation of the cervix as far as the

internal os, but with no apparent benefit. I then advised immediate miscarriage, which we produced by dilating the canal and internal os, inserting a catheter; the woman, however, was so far advanced toward death, so weak, that miscarriage was not complete at the time of her death; that is, so weak that the uterine muscular fibres were so thoroughly exhausted that the fœtus was never expelled fully during life. I may add that she had had evidences of miscarriage, these evidences having existed all along and we were hoping all the time this would occur spontaneously. The day she died the doctor made an examination and found the fœtus partly expelled from the womb; she sank rapidly and certainly died from this pernicious vomiting, and I want to put this case on record as such. The urine was examined and no evidences of special trouble found. She had a low grade of fever, which during the last week of her life was similar to the last week of typhoid fever. The first time I saw the patient her temperature ranged from 101° to 102°F.

This patient never retained anything taken as food except the white of an egg. She was fed per rectum as long as she could retain anything. The injection soon produced rectal irritation, and could no longer be used. The accomplished obstetrician, DuBois, divides this subject into three stages, very similar to the typhoid condition, and I thoroughly agree with him. He says it is not right nor fair to the patient to wait until the last stage to perform a miscarriage, because, at that time, the patient is so thoroughly exhausted that the shock of miscarriage carries her off. The time he advocates or indicates as proper to induce miscarriage, is during the second stage; that is, when the woman has a decided fever and is unable to retain any nourishment, when every other possible means, therapeutical or local, dilatation of the cervix and everything else has failed. I perfectly agree in this, and believe if miscarriage is brought on at this stage, the chances of recovery are greater than if it is delayed until the last stage, when all the powers are waning.

The attending physician dilated the internal os upon my advice; that is, I believed in going step by step. We frequently have heard of cases, no doubt all of you have, where ulceration of the cervix

associated with persistent vomiting, has been cured by the single application of nitrate of silver solution, where relief has followed the single introduction of the finger into the internal os. I think many of these cases have been benefitted by gradual dilatation of the cervix, that is, step by step, the finger eventually getting to the internal os, as we did in the case under question, at the last moment. My advice to the attending physician was that as long as she was having evidences of a miscarriage, that is, having pains, which seemed to indicate that she might have a miscarriage, possibly any dilatation would excite it, and the least we did the much better her chances would be. I believe that the internal os can be dilated with much advantage in these cases, but I believe also that the risk of miscarriage would be much greater. With the finger you can dilate the os to that extent and probably not bring on a miscarriage, though if the tendency was very strong, I am inclined to think miscarriage would be induced.

COCAINE POISONING.

By J. B. MATTISON, M. D.

MED. DIRECTOR, BROOKLYN HOME FOR HABITUÉS.

In November, 1886, at a meeting of the Neurological Society, Dr. Wm. A. Hammond, speaking of cocaine, said, "He did not believe any dose that could be taken was dangerous." This statement—mistaken, misleading and dangerous—was promptly challenged by the writer; and, in two papers—"Cocaine Dosage and Cocaine Addiction," London *Lancet*, May 23, 1887; and "Cocaine Toxæmia," *La Tribune Medicale*, Paris, Jan., 1 1888—seven deaths and 119 less lethal cases from this drug were cited; a record that impelled the *British Medical Journal* to editorially assert "if it were needful to produce more proof of the unsoundness of Dr. Hammond's statement, Dr. Mattison has effectually done this."

In a third paper—"Cocaine Poisoning," MEDICAL AND SURGICAL REPORTER, Oct. 24, 1891, covering the record to March, 1891—six more fatal cases and over eighty less toxic were noted, making in all thir-

teen deaths and nearly two hundred other cases.

In a fourth paper—soon to appear—we shall note those reported from March, 1891, to September, 1892, and among them the one here detailed, for which I am indebted to the courtesy of Dr. G. B. Cushing, House Surgeon of Bellevue Hospital, in whose service it lately occurred.

A. B., strong, healthy man, walked into hospital, suffering from retention of urine. Had clap twelve years ago. During last five years, occasional trouble in urinating. On inserting catheter found a stricture four and a half inches from meatus. To prevent pain and spasm, one drachm of a four per cent. cocaine solution was thrown into urethra, held a half minute, and then allowed to escape. Almost at once, patient became very excited, with largely dilated pupils, and in a few seconds went into violent convulsions, so severe that it required the combined strength of doctor and nurse to hold him on the operating table. Nitrite of amyl was promptly used, but there was not the slightest reaction, and in four minutes the man was dead.

The autopsy revealed nothing abnormal except intense congestion of heart, lungs and brain.

This case emphasizes the need of care in all cases of cocaine anæsthesia, and makes pertinent the reiteration of these conclusions:

1. Cocaine may be toxic.
 2. This effect is not rare.
 3. There is a lethal dose of cocaine.
 4. This dose is uncertain.
 5. Dangerous or deadly results may follow low doses usually deemed safe.
 6. Toxic effects may be sequence of doses large or small, in patients young or old, the feeble or the strong.
 7. The danger is greatest when given under the skin.
 8. Cardiac or renal weakness increases this risk.
 9. Purity of drug will not exempt from the result.
 10. Caution is needful under all conditions.
 11. Réclus' method, Corning's device, or Esmarch's bandage should be used when injecting.
 12. Nitrite of amyl, hypodermic morphia, hypodermic atrea, alcohol, ammonia and caffeine should be at command.
- Brooklyn Avenue, Brooklyn.

Society Reports.

THE CLINICAL SOCIETY, OF
LOUISVILLE.*Stated Meeting, Oct. 4th, 1892.*THE PRESIDENT, Dr. P. Guntermann,
in the chair:CALCAREOUS DEGENERATION OF A FI-
BROID TUMOR.

DR. W. H. WATHEN: About two or three months ago a patient was referred to me by Dr. J. M. Mathews, who had been under his care for some time with intense trouble referred to the rectum. Upon thorough examination, he reported that he could find no disease whatever in the rectum, and thought there must be something in the pelvic cavity outside of the rectum that would account for this constant trouble. It seems that this woman had been treated for several years by other physicians, before she came under Dr. Mathews' observation. On examination I found in Douglas' sack a movable tumor, very hard and about the size of a hen egg, which I supposed accounted for all her trouble. I diagnosed fibroid growth, but its origin I could not make out; in fact, the diagnosis was by no means positive, because I do not believe it possible to make an absolutely correct diagnosis in these cases. The woman was operated on about eight weeks ago, and the specimen that I exhibit to you, removed. There was nothing unusually interesting either in the operation or progress of the case. She made, as she ought to have done, an uninterrupted recovery and has none of the symptoms she complained of before the operation. But my special reason for reporting this case is, that while it is not entirely unique, it is an unusual condition, as may be very easily seen upon examination of the specimen. It is a fibroid growth with calcareous degeneration. Its origin, as you will see, is peculiar; it is in the folds of the broad ligament, and has no connection with the ovary, tube or uterus. There are a few cases of this nature recorded, but they are very rare and probably many laparotomists of large experience have never met with such a case. Dr. Dugan assisted in the operation, and Dr. Mathews was present.

DISCUSSION.

DR. J. A. OUCHTERLONY: What Dr. Wathen has said is very interesting, but there is something left out, which I think is essential to our understanding of the case in all its bearings. He mentioned that the woman had been suffering from trouble, and she was relieved, but he failed entirely to state in what the trouble consisted; what were the symptoms which the presence of this tumor had given rise to.

DR. J. M. MATHEWS: This woman was under my observation for about a year. She complained almost entirely of rectal pain, aggravated or increased during defecation. So well marked was this symptom that I suggested putting her under the effect of an anæsthetic and investigate the rectum, which I did. Chloroform was given her, and divulsing the sphincter I searched the rectum but could not find any well defined ulceration, or indeed inflammation; however, the simple divulsion of the sphincter gave her considerable relief for two or three months. She came to my office several times very much improved, but after the lapse of several months she complained of the same distressing symptoms, which she said had become unbearable. I made another careful examination of the rectum with speculum, but finding nothing I referred her to Dr. Wathen, who made an examination and found this tumor which I had been unable to detect; perhaps had not examined her in the manner or by the method employed by him. It was suggested that an operation was advisable, to which she readily consented, because she said the pain had become unbearable. She was promptly relieved by the operation, and I believe the tumor which you see here, was the cause of all this rectal distress.

DR. W. C. DUGAN: I am rather surprised that it was fibroma; I was under the impression that it was a par-ovarian sarcoma. Am very glad for the patient's sake that it was fibroma.

DR. J. A. OUCHTERLONY: The case reminds me of a post-mortem examination I made a good many years ago, in which there was a double tumor of the broad ligament. The tumor on one side was about as large as the head of a child two years old, on the other it was somewhat smaller. They were ovoid in shape, involving the whole broad ligament; neither ovary could

be distinguished, and both tumors were the seat of calcareous degeneration. The nature of the case had not been determined during life. This is the only case of calcareous degeneration of neoplasms occurring in the broad ligament that I remember ever having seen, and I believe this condition to be very rare.

VAGINAL DOUCHE AFTER VAGINAL HYSTERECTOMY.

DR. W. H. WATHEN:—This is a uterus removed from a woman forty-four of age. The history of the case is about as follows: For a year preceding the time she applied to me, she had been having a discharge from the vagina of, first a muco-sanguineous character, then a mixture of blood and pus, and finally a well defined hæmorrhage, which, she supposed, was a return of the menstrual function. She had some pain and weight in the pelvis. Her husband, a prominent physician, then examined her and detected what he supposed to be an incipient epithelioma. He treated her by local applications and vaginal douches for six months, when he referred her to me. The hæmorrhage had gradually increased and for three months before she consulted me, it had been almost constant. The posterior cervix was involved, and a portion of the anterior cervix and posterior vaginal walls down to nearly the bottom of Douglas' pouch. She was very anxious to have the organ removed, and her husband insisted upon it. About six or seven weeks ago a vaginal hysterectomy was done. I neglected to say that the womb was completely retroverted, lying upon the rectum, but it was not adherent. The only apprehension I had in the removal of the womb was the difficulty in getting far enough back to go behind the malignant growth and not invade the rectum. The womb was removed without any especial trouble and no untoward symptom worth relating developed in the history of the case, until on the morning of the fifteenth day. Her regular nurse had been dispensed with on the fourteenth day; the nurse attending the convalescing patients at the infirmary took charge of the case, and, as is her custom, with a desire to preserve cleanliness, she gave a vaginal douche of about as much or more than a quart of bichloride of mercury solution 1 to 1000 or 1 to 2000. Very little of the water returned, but the nurse continued to inject

it all. The woman began to suffer intense pain. The nurse thinking that possibly the solution was too strong, injected some water without any bichloride in it, how much I do not know; she said about a quart, she thought, and very little of that returned. I was telephoned that the woman was suffering intensely and sent my nurse at once who telephoned the condition; and gave the patient a hypodermatic injection of morphine. I saw the patient in an hour and the water was flowing from the vagina, keeping everything wet; about every five or ten minutes she would have quite severe labor-like pains, when the water would gush from the vagina, showing that it had been forced into the peritoneal cavity. She suffered so much that it required one-fourth grain of morphine about every three hours until the next day, when the pains gradually grew less but continued for probably three days before she was entirely relieved. I observed the next morning that she was passing no urine, and upon introducing a catheter into the bladder, only a dram or so came away. The nurse informed me that evidently the character of the water then was practically urine. The catheter was retained and part of the urine escaped through it at first, gradually increasing until at the end of ten days it all passed through the catheter, the wound in the bladder and in the peritoneal cavity having closed. I report this case to emphasize my position expressed three years ago before the meeting of the American Association of Obstetricians and Gynecologists, that vaginal douches following vaginal hysterectomy are practically of no advantage, and may result in serious injury by forcing the solution, bichloride or what not, and necrosed tissue, into the peritoneal cavity. I was severely taken to task then, others claiming that water injected into the vagina would always run out; but here is a practical demonstration that it went into the peritoneal cavity. I was surprised that the solution of bichloride should have caused so little trouble, because it must have come in contact with a considerable portion of the peritoneum, and organs of the pelvis. I received a letter from her husband about a week ago; he says she is doing well and retains her urine for nine hours.

I would like to call attention to one

other point: About a year and a half ago, I lost a patient from vaginal hysterectomy, caused I am sure by the neglect of a precaution I now take. It was evidently caused by failure to remove by curetting all the infected tissue. Everything used in the operation, and the entire cavity should be thoroughly sterilized; every suspicious particle of tissue carefully scraped away, the cavity thoroughly washed with bichloride solution and tamponed with iodoform gauze. I think that many deaths from vaginal hysterectomy have resulted because of failure to carefully cleanse and scrape away all the infected tissue, thereby admitting the poisonous germs into the the peritoneal cavity.

DISCUSSION.

DR. W. C. DUGAN: Concerning the occurrence of malignant growths, or malignant diseases in young persons, I saw a patient a short time ago, aged twenty-two years, who was suffering with a peculiar ulceration of the cervix; suspecting malignancy, I cut out some tissue and gave it to a microscopist for examination, and he pronounced it unquestionably malignant.

DR. J. M. MATHEWS: In regard to the point made by Dr. Dugan, I wish to state that I lost a young lady patient, eighteen years of age, with malignant trouble of the rectum, and a young boy, seventeen years of age, of the same trouble.

DR. A. M. VANCE: I would like to mention a case I saw recently at the Johns-Hopkins Hospital, operated upon by Dr. Kelly by vaginal-hysterectomy. The operation was quite successful, and the woman made a good recovery. At the time I saw the patient he was very much surprised to discover in the vault of the vagina a mass of protruding tissue. Upon investigation he became convinced that it was omental hernia, which was easily removed by galvanic-cautery, only a very small pedicle being present. The tumor protruding was about the size of an English walnut. This shows that the opening remained some little time after vaginal-hysterectomy.

DR. J. G. CECIL: In this connection, I want to report a case that I saw once which was operated on by Marcy, and in which there was complete closure of the

opening, and the trouble had recurred in the cicatrix. Another case I remember was operated on by Price, in which there never was a closure of the opening through the vault, but in the last case there was a recurrence of the trouble probably within six weeks or two months. The opening never did close yet there was no trouble resulting from the vaginal-douches, that is, no such trouble as Dr. Wathen experienced in his case.

DR. W. C. DUGAN: Did you not attribute the trouble of non-union to malignant growth which was not wholly removed?

DR. J. G. CECIL: We thought failure of the opening to close was due to early recurrence of the malignant trouble.

DR. A. M. VANCE: In the case referred to by me, operated upon by Dr. Kelly, the mucous-membrane coming up to this little mass, was perfectly soft and gave no evidence of infiltration, nor was there any in the mass after removal. The pedicle was about one-quarter of an inch in diameter.

DR. W. H. WATHEN: The trouble in this case was evidently due to the fact that in operating, the vaginal-vault was left open, and the omentum immediately slipped in, blocking and preventing its closure. I would like to ask if ligatures were used in the operation.

DR. A. M. VANCE: The operation was done with ligatures, some of which were still on.

UREMIA CAUSED BY MALIGNANT TUMOR.

DR. J. A. OUCHTERLONY: I will mention a somewhat unusual case that came under my observation. A lady past middle age, who had several years ago ceased menstruating, noticed the latter part of last year a sanguineous discharge per vaginam, which disturbed her considerably. At first she thought it was a return of menstruation, but it occurred at irregular intervals and she suffered some discomfort in the lower part of the abdomen, not very definitely located. At last she consulted me; I examined her and found an epithelioma of the cervix and upper part of the vagina, so extensive in its implication of the surrounding tissues, that I did not think an operation was at all likely to prove servicable. I treated her with astringent washes, etc.; in the course of

time she began to suffer more pain, which became so intense that I put her on small doses of codeia; repeated several times during the twenty-four hours. This kept her comfortable, and the washes did away with the unpleasant discharge and she got along very nicely. I told the family the nature of her trouble, and this summer the question was agitated by some of her relatives whether something could not be done. A friend of mine saw her with me, and agreed that it was not a case for operation. I went away on my vacation and in the meantime she had to increase the dose of codeia so that she took about one and one-half grains three or four times a day. When I returned early in September, I found her at home after a sojourn in the west, looking better and having become stronger. After I had been at home a week or so, I was sent for one day, and she informed me that she was unable to pass water. I gave her a diuretic, which produced no impression at all; then I introduced a catheter and got nothing but some sanguineous, milky fluid. I employed a silver catheter which could be moved around, using as a probe, and found that the posterior walls of the bladder had become involved in the malignant processes, and was almost completely filled with this epithelial mass. She was suffering from nausea, and could retain nothing; I gave her some wine of cocaine which seemed to relieve the nausea, and she took a little nourishment, but the urinary function was never re-established, and she died after two weeks, in which time she had never passed any water at all; some fluid perhaps amounting to a tablespoonful escaped per urethra in the course of each twenty-four hours. While this was going on there was a soft fluctuating tumor developing in the right flank. My diagnosis of the case was as follows: "Malignant processes involving the orifice of the ureters, preventing the entrance of the urine into the bladder," and for that reason she was enabled to live so long without passing any water. She had a few convulsions, and all of a sudden one evening she had a severe convulsion and was gone.

I do not remember every having seen exactly the counterpart of this case; it interested me a great deal. It is an unusual way for malignant disease of the uterus to terminate.

DISCUSSION.

DR. T. P. SATTERWHITE: I believe it is common for malignant troubles to cause uremic poisoning.

DR. J. A. OUCHTERLONY: Why should there be uremia in malignant disease of the uterus, unless the disease involves the kidneys?

DR. T. P. SATTERWHITE: I have seen two cases of malignant trouble of the mammary glands, both patients dying of uremic poisoning.

CANCER AND LIFE INSURANCE.

DR. J. G. CECIL: The case reported by Dr. Ouchterlony is certainly a very rare one as far as my observation goes, in the manner of its termination. I have often wondered why it was we see extensive disease involving the anterior vaginal walls, and that the ureters so frequently and so generally escape. This case of cancer recalls to my mind one of some importance from an insurance standpoint, which came into my knowledge recently. A woman down town was examined by two gentlemen for life insurance, and she gave as far as the reports went, a clear history with the exception that she did not give any history of malignant growth; but it was afterwards learned that she had had a small growth taken from the ala of the nose, which had been diagnosed by an irregular as cancer, some two or three years previous. She passed the examination into a company which is reasonably rigid, I think, for three thousand dollars, and a short time afterward, within a week or two at least, she had a hæmorrhage, and sent for Dr. Turner Anderson, who went to the house and found the woman out in the garden working about the flowers or vegetables. The doctor asked her if anyone was sick, and she said no, and he told her he had been summoned to that house; she replied that perhaps it was herself, as she had had some little hæmorrhage and wanted to know about that. He made an examination and detected very easily an extensive carcinoma of the cervix. She was past the menopause, probably fifty-five years of age. The next day after the examination, I believe, a friend of hers, relative, perhaps, came to Dr. Anderson and asked him what he had learned by his investigation. Dr. Anderson told the party he had learned that the woman had

a cancer. This lady was informed of the fact that she had a cancer, whereupon she laid down and died. She died within a week or ten days from the date of Dr. Anderson's examination. The question that is agitating the insurance company is whether they will have to pay the policy or not. I do not know exactly how she died, but the method of her death as related by the physician in attendance would seem to indicate acute peritonitis.

DISCUSSION.

DR. A. M. VANCE: I remember the case of a young medical student, where a tuberculosis process closed the ureters, and the patient died in a short time with convulsions. No hydro-nephrosis developed, and he died in three days after suppression had commenced. The process commenced in the testicles and went from that to prostate, thence to the bladder walls, shutting off the ureters.

DR. J. M. MATHEWS: The point made by Dr. Cecil is an important one in relation to life insurance. Five years ago I read a paper before the State Medical Society, of Kentucky, on the subject of the importance of rectal examinations by life insurance examiners. In that paper I cited five cases, one of which I wish to mention briefly: A gentleman was referred to me by Dr. Leachman, for some inflammation of the rectum, supposed to be piles. I made an examination with my finger and detected quite a large nodule. I asked the gentleman to bring Dr. Leachman with him to my office; after a delay of about a week the Doctor came with him. I had the Doctor touch this nodule, which was about three to three and one-half inches up the rectum, saying that I thought it was malignant. At that time the Doctor hardly thought so, as the man appeared to be in excellent health. The man was given comparatively little treatment; I gave him an injection, and he said he felt improved. He then left for a long trip west and was absent several months. On his return he came to my office, stating that he was positively relieved had no trouble at all. I examined the rectum and found ulceration considerably increased. He then left my office and made application to one of the life insurance companies for a ten thousand dollar policy, and was accepted.

The growth rapidly extended and in less than six months from that time the man was dead, evidently from perforation caused by cancerous growth. This growth could be detected by simply passing the finger in the rectum, and if the examiner for life insurance had done this, it would have saved the company ten thousand dollars. It is my experience that these growths occur in the rectum often without any pain at all; that the rectum may be almost closed by the growth without causing pain; and, that they can be easily detected simply by an examination with the finger, without the aid of a speculum.

DR. W. H. WATHEN: The case referred to by Dr. Ouchterlony is unusually interesting, and, as far as my experience goes, entirely unique. I think I have seen relatively more cases of cancer of the womb than of any other disease, and have never known a case resulting as he has described. You seldom find the ureters obstructed; the flow of urine constantly coming away, the pressure from behind forcing it through, prevents the passage becoming obstructed; but in this instance doubtless something encouraged the rapid growth of the cancer, which obstructed nearly the entire flow. From the explanation given by Dr. Ouchterlony I feel sure the uremia was due to the obstructed ureters. I have never observed any relation between cancer and kidney complication, and do not see why there should be any, unless the kidneys or the ureters are involved in the cancerous growth.

Concerning Dr. Cecil's inquiry as to the part cancerous disease of the uterus assumes toward life insurance, I think this is quite an important matter, but one however, that will probably never be fully and practically appreciated, for the reason, that women generally will not complain to insurance examiners of any symptom that would indicate a disease of this nature. It has probably been the experience of all of us in the treatment of cancer of the womb, that patients do not apply for examination until the disease has progressed beyond operative means. I think nine-tenths of the patients, if not nineteen-twentieths, that have consulted me, have gone so far that an operation could not be performed. Many of these I have examined when they had complained but little, and had not suspected malignant disease.

DR. W. C. DUGAN: I remember a few

years ago hearing Thomas make the statement that the return of menstrual flow after the menopause usually meant malignancy, and in such cases the patients should be subjected to careful examination at once. This clinical fact, I am convinced, is not generally appreciated.

DR. J. A. OUCHTERLONY: I have read of a number of cases where there was a return of the flow which continued with perfect regularity for a considerable length of times in which there was no malignancy.

Of course such cases are rare, but they do sometimes occur.

DR. T. P. SATTERWHITE: I wish to state in connection with Dr. Mathews' remarks, not long ago I was called to see a lady about seventy years of age, the very picture of health. She said she had some little trouble with constipation, for which I prescribed saline waters. She sent for me again in two or three weeks; I examined her rectum and found it was nearly closed; as well as I could judge from my index finger, I do not think the opening through the stricture was larger than one-quarter of an inch, and she was as healthy and robust a looking woman as I ever saw.

PERNICIOUS VOMITING OF PREGNANCY.

DR. J. G. CREIL: (See page 726)

DISCUSSION.

DR. W. H. WATHEN: I am opposed to the induction of miscarriage in cases of this character, but I feel that we may be justified in resorting to means that may bring on miscarriage, not for the purpose of bringing it on but for the relief of the nausea. I should not hesitate where I had a patient that had resisted all other means, whether she might be threatened with miscarriage or not, to gradually and carefully with my finger, dilate the entire canal to a limited degree. Sometimes the dilatation in a case of threatened miscarriage might have a soothing effect by relieving the irritation within the cervical canal. There are some instances where dilatation has resulted very rapidly in miscarriage; in others where it does not result in it at all. I have seen the neck dilated to the extent of a half dollar in a woman pregnant four and one-half months, and the sound introduced several times between the membranes and the walls, not bringing on a symptom of miscarriage. The physician who did this contended

that the pregnancy was extra-uterine, because he had introduced the sound without producing miscarriage. I introduced my finger and found the head of the child easily within the membranes. She went on to full term.

I have found a number of cases where a properly adjusted pessary has been the means of preventing miscarriage in retroverted wombs.

GNORRHEA.

Dr. John A. Wyeth, in a clinical lecture at the New York Polyclinic, said: My idea about gonorrhea is that we should treat it just as we do an acute abscess: that is, by drainage, with just as much asepsis as possible. Let the urethra hang downward, with a bag of some sort loosely attached to it to catch the discharge. Do not have it tightly bandaged or plugged up with cotton. In a specific urethritis, where the inflammation has extended into the deeper layers of the epithelium, the various bichloride and zinc injections are not likely to do much good. In an ordinary non-specific urethritis, however, where the inflammation is superficial, you can inject with good results. There are certain remedies which will increase the amount of urine and render it aseptic, so that you can use the bladder as an irrigator in gonorrheal inflammation. Among these remedies is boracic acid, or better still, the oil of gaultheria. This drug will absolutely sterilize the urine. You can give five or six drops every three or four hours. During the later stages of inflammation, mild solutions of the sub-acetate of lead can be used, which will help keep the urethra clean. A syringe with a short nozzle should be employed so as to only just enter the meatus. The injection should be of moderate size, so as not to over-distend the urethra. During the acute stages I instruct my patient to take a warm sitz bath night and morning. When the acute stage has subsided the administration of some of the so-called blennorrhetics will be found beneficial.

I have found the capsules containing Santal-midy, a preparation made from sandal-wood, a very good thing. I consider these superior to the old-time cubeb preparations, which are liable to disturb digestion.—*Indiana Med. Journal.*

Bacteriological Notes.*

A METHOD FOR OBTAINING PURE CULTURES OF TUBERCLE BACILLI FROM SPUTUM:—Dr. E. Pastor (*Centralblatt f. Bakteriologie u. Parasitenkunde*, xi, 1892 p. 233) has announced a method for obtaining pure cultures of tubercle bacillus from the sputum. He selects sputum which contains a very large number of bacilli and comparatively few other bacteria. The patient is then made to wash out his mouth repeatedly with sterilized water after which he expectorates in a sterile dish. This sputum is emulsified by shaking it up with sterile water and any coarse particles filtered off with fine gauze. A few drops of the filtrate are added to tubes of liquid gelatine (10 per cent.), thoroughly mixed with it after which it is poured out on plates. These are properly covered and left at the temperature of the room. In the course of a few days the other bacteria, present in the filtrate, develop colonies. By means of a hand lens areas can be found on the plate which are free from colonies. These are removed by means of sterile instruments and tubes of inclined blood serum inoculated with them. These are kept at the body temperature in an incubator. The author always obtained as many as one, (frequently more) cultures of the tubercle bacillus out of a series of ten inoculations. Many of the tubes became contaminated owing to the non-development of certain bacteria at the ordinary temperature. Better results were obtained from the fluid in the cavities of phthisical lungs which as would be expected contain more tubercle bacilli and less impurities than the sputum.

APPEARANCE AND SPREAD OF MICRO-ORGANISMS IN THE ALIMENTARY CANAL OF ANIMALS:—Popoff (*Wratsch*, 1891, No. 39.) examined bacteriologically the meconium of calves and the contents of the intestinal canal of newly born cats and dogs. In the latter case some of the animals had been suckled, others had not. The conclusion reached was that the meconium contains under physiological conditions neither aerobic or anaerobic bacteria but it

afforded a good medium for the development of bacteria that might be introduced. The time of the appearance and spread of the bacteria depends entirely on the milk. The only way by which bacteria can enter the intestinal canal is by the mouth. Bacteria can be demonstrated in the meconium twenty-four hours after birth.

Brienstock maintained that bacteria would not be found in the meconial feces of children fed only on milk. Echerich however discovered bacteria in the rectal contents in from four to eighteen hours after birth. In the light of their former experiments the results of Popoff are of considerable importance.

A PUS-PRODUCING BACILLUS OBTAINED FROM EARTH.—Dr. Bolton (*The American Journal of the Medical Sciences*, ciii, 1892, p. 673) described a bacillus which he isolated from earth by inoculating rats. The bacillus resembled morphologically the bacillus of diphtheria. Many of them are bent and narrower throughout the middle than at the extremities. It does not take the Gram stain. It develops most vigorously in a slightly acid medium. In rats, gray mice, rabbits and usually in white mice a subcutaneous inoculation with a small quantity of a pure culture produced an abscess confined strictly to the seat of inoculation. The injection of .5 cc of liquid cultures in the veins of rabbits produced in some cases multiple abscesses, especially in the joints and kidneys. Subcutaneous inoculations produced in one case abscesses of the joints in a white mouse. The abscesses developed very rapidly after the inoculation, but suppuration ceased as soon as they were opened. The animals appeared to suffer no other inconvenience. The bacteria were found aggregated in small and larger irregular clumps in the pus many of them lying in the pus-corpuscles. Metastatic abscesses were formed only when the bacteria were injected into the circulation otherwise the abscess remained strictly confined to the seat of inoculation in rabbits, white rats and gray mice.

In the same article the author gives an interesting account of the cultivation of tetanus bacilli. He obtained pure cultures of these bacteria from different specimens of soil and also from a case of human tetanus by the use of Kitasato's method.

*Translated for THE MEDICAL AND SURGICAL REPORTER.

Abstracts.

ACTUAL, NOT TEXT-BOOK, EXPERIENCE WITH CASES OF ECTOPIC GESTATION.*

By DR. JAMES F. W. ROSS,
TORONTO.

After showing the want of reliability of text-book lore, since they for the most lack that knowledge gained by actual experience and hence are given to lead the student astray, the author credits the pioneer work of Lawson Tait coupled with his teachings, to have been the means of saving several hundreds of lives. Ross confines himself entirely within the realm of his own personal experience and sets forth many instructive facts, well to be borne in mind by the general practitioner so the patient in question may receive prompt surgical assistance.

HISTORY.—(a) *Sterility*: "Which becomes the cause of fertilization of the ovum and its non-removal from the tube," he explains by the fact that "many of these patients contract gonorrhœa soon after marriage, but to a minor degree; the ciliated epithelium is shed, and the tube is functionally imperfect." (b) *Supposed miscarriage*: Experience shows that uterine bleeding may occur when a pus-tube or ovarian cyst is present, can only be relied on if the decidua is found. (c) *Pain*: Of great importance. The woman has been practically a well woman until it set in, no evidence or history of recent gonorrhœa, no miscarriage, no intermittent attacks of inflammation, but while progressing well, though barren, she suddenly, in the midst of health becomes an ill woman. Ectopic gestation is the only disease that will produce this condition.

Digital examination may be puzzling in that the condition feels neither like a pus tube or cystic ovary, too soft for a fibroid with a pedicle, too hard and too movable for a hydrosalpinx, that takes some eccentric position between uterus and bladder, and simulates that disease of the ancients, "pelvic cellulitis." A guess of ectopic gestation will probably be correct.

Rupture of an ectopic gestation may or may not give rise to symptoms; a woman

may be going round with blood in her abdomen without showing any definite signs of its presence; and yet *peritonitis* may supervene at any moment. This is shown by an elevation of temperature and pulse, and calls for immediate surgical interference, otherwise the patient's life will be sacrificed. Hematocele is nearly always connected with ruptured tubal pregnancy, to substantiate this the author showed a specimen of an enormous suppurating hematocele, the fetal sac was almost overlooked, lying as it did, high up among the intestines. The author reported seven cases with six recoveries, results which amply justify his conclusions. "In all cases of obscure miscarriage with a doubt as to the previous abortion, with a mass in the pelvis and unaccountable pains, a consultation should be called before the patient lapses into a critical condition. An operation should then be performed, partly exploratory and wholly curative."

THE TREATMENT OF OBSTINATE HICCOUGH.

It is doubtless perfectly true that the treatment of hiccough has not received much notice at the hands of the writers of text-books in this country. But the reason of this probably is that the symptom seldom attains to any serious proportions in this part of the world, so as to call for relief by the medical man in attendance. When, however, hiccough acquires an obstinate persistency, for the relief of which therapeutic aid is urgently needed, difficulties may be met with. A case in point is recorded in an Indian contemporary, where a retired officer aged 76, who had been suffering from acute congestion of the liver became affected with obstinate hiccough, which set in as a most alarming and distressing symptom. Everything was tried in the way of drug treatment which could be suggested, but without avail. One day, however, some beef tea was taken, which incidentally caused the patient to vomit. For a time, in consequence of this, the hiccough was relieved; whereupon the practitioner determined to try an injection of apomorphine, and the result was that vomiting was produced, and the hiccough ceased permanently. Altogether the symptoms persisted incessantly for seventy-two hours, and caused much distress to the patient. Physostigma has been recommended as useful in these cases.—*Med. Press.*

*Read before the Medical Society of the County of Erie, Buffalo, June 14, 1892.

THE RELATION OF THE SO-CALLED MINOR GYNÆCOLOGICAL OPERATIONS TO INTRA-PELVIC INFLAMMATION.

L. S. McMURTRY, M. D.,
LOUISVILLE, KY.

The author calls attention to the advance of civilization, the departure from simple habits of agricultural life, the accumulating influx of European pauper population and an increase of vice, as augmenting the prevalence of specific inflammatory disease of the pelvic organs. The ready infection of the intra-peritoneal structures during an unprotected labor or puerperium, as a conspicuous cause of intra-pelvic inflammatory disease.

Under the head of *pernicious effects of unnecessary examinations*, he states that not every woman with pain in back and head at menstrual period should be regarded as a subject of uterine or ovarian disease, salines, hot sitz baths and rest generally giving relief. Opium is decidedly contraindicated and dangerous. The author recognizes mechanical dysmenorrhœa either from cervical stenosis or imperforate hymen, but claims their proportion to be limited, and when local examination becomes necessary in the unmarried, she should be anesthetized. The sound he denounces as a bearer of infection, and a means by which the uterine walls have been punctured, hence dangerous and useless.

Under the *use of caustics and chemical solutions*, the doctor speaks truly and feelingly: "I could recite here case after case from my own practice, showing beyond question that mild forms of pelvic inflammation have been converted into serious and acute grades by this treatment, and that disease of the tubes and ovaries dated its activity from the time such treatment was instituted." He therefore endorses Emmet's teachings on the evils of intra-uterine medication.

Dilatation of the cervix uteri resorted to by some for sterility, dysmenorrhœa, on the assumed diagnosis of stenosis of the cervical canal. 1. Sponge or tupelo tents, often within twenty-four hours give rise

to elevation of pulse and temperature and the patient has an attack of pelvic peritonitis and its sequelæ of chronic inflamed appendages. 2. Graduated hard rubber dilators, produce a traumatism which may extend itself readily through communicating channels to the peritoneum. 3. Steel dilators most often used, have been erroneously credited with curing menstrual disorders and nervous disturbances associated therewith; and have no place in nervous dysmenorrhœa,—the author recognizes the necessity for dilatation of the cervical canal, by a gentle hand under asepsis as a preparatory step in the removal of pathological growths from the uterine cavity, but feels the indiscriminate and persistent use of dilatation is a common and prolific cause of disease of the uterine appendages.

Indiscriminate Trachelorrhaphy. The operation, one of the most appropriate and efficient in deeply torn ulcerating cervixes, has been widely abused in having been performed for every variety of pelvic disease and almost every form of nervous disorder. It has unfortunately been also done in cases of unrecognized intra-pelvic inflammations or the lack of proper precautions and aseptic methods have given rise to more serious conditions than the operation was undertaken for.

The routine use of the curette. Its usefulness in the removal of fungous growths from the endometrium, or removing all kinds of detritus from the interior of the uterus, has long been recognized. Its use in simple endometritis (a rare disease) is questionable, results often showing an aggravation of intra-pelvic disease.

In conclusion the author presents the following summary: 1st. Etiology of intra-pelvic inflammation (salpingitis, ovaritis, and peritonitis) may be therefore: (1) puerperal; (2) specific (3) post-operative (traumatic).

2. Unnecessary and uncleanly examinations, with introduction of the sound, may cause by traumatism and infection, pelvic inflammation.

3d. Forcible dilatation, with steel instruments, sponge tents and other instruments, may beget intrapelvic inflammatory disease. This operation has a very narrow sphere of utility, and is usually performed upon erroneous pathological data.

4th. Operations on the cervix with associated disease of the appendages is dan-

*Read before the Med. Soc. of the County of Eric, June 14, 1892.

gerous. The treatment of lacerations by caustics and astringents is never satisfactory and always dangerous. Trachelorraphy is an operation of high utility, but requires discrimination in application and skill in execution in order to obtain good results. It is often the initial step in tubo-ovarian disease of severe type.

5th. Curettement, while of unquestioned value in removing neoplasms and detritus from the endometrium, is abused as a method of treating inflammatory conditions of the pelvic organs. The curette is an instrument capable of causing extensive lesions, that may light up an inflammation extending to the appendages and peritoneum, or aggravate a pre-existing inflammation therein.

THE NATURAL HISTORY OF PELVIC INFLAMMATIONS.

By JOSEPH PRICE, M. D.,
PHILADELPHIA.

The author begins with the pregnant remark that all affections should be studied from the clinical and symptomatic standpoint, this should be reinforced or corrected by such pathological data presenting themselves along the line of investigation.

The various forms of pelvic disease studied from this standpoint have enabled the author to assert definitely that in his experience he has never met with a broad ligament abscess; in the most purulent inflammation discoverable in the broad ligament, in tubal and ovarian disease, he has always found the ligament intact. It might be often folded on itself, glued together, and apparently fused with the abscess cavity, but careful dissection would free it, and the ligament, except for inflammatory cloudiness due to adhesions, was in no way attacked by the pus deposit; he states further that "this is the invariable rule when removal is made *in toto*. This is why almost without exception all these pelvic tumors are removable. The broad ligament is the swing upon which is held the inflammatory neoplasm, and when intestinal and omental adhesions are

loosed, the whole deposit may be lifted out and removed."

The conclusions drawn from the above facts, are, that almost without exception the *sources of inflammation come from the outside*. Its natural passage is through the uterus, along the tubes where it is likely to stop since the fimbriated end is prone to glue up, but this often happens only after the ovary has been infected thus giving rise to the ovarian abscess and its possible subsequent complications. The causes for pelvic inflammation may be natural or artificial—referring to the latter he states: "*I am sure that many women are treated into pelvic disease*," and cautions about the use of the improper use of the vaginal douche, viz; during the menstrual period, or used at any time with great force, the danger being the occurrence of possible traumatic inflammation; the use of the sound and intra-uterine application, etc., are mentioned as other causes.

Under the head of natural causes, are gonorrhoea, badly-handled labors and abortions, and the accidents to menstruation, those belonging to this latter class could be avoided, if proper instruction regarding necessary care during menstruation, attention to proper hygiene and the ruder forms of exercise and the fatigue of the ball-room.

The exact history of previous pregnancies, abortions and labors, their management, excessive douching at the puerperal period with excessively strong irritating solutions, the use of instruments at labor, the after-history in reference to discharges, retained placenta and long-continued bleeding are all competent to produce trouble along the channels already designated; he further states that, "the diagnosis, apart from history, must rest upon digital examination. The presence of lateral masses in the pelvis, our old cellulitic deposit, must give us our point of inquiry. First the uterus should be differentiated, after which, taking this as the objective point, all other relations are to be decided,—the ovarian abscess and its subsequent complications."

Among the causes of pelvic inflammations he enumerated: The presence of a well-defined groove between the lateral masses and the uterus, points invariably to pelvic inflammatory deposit in the tubes and ovaries. The patient may

*Read before the Med. Soc. of the County of Erie.

suffer intensely on one side, and the disease be present on the other, hence, both sides should be examined.

Again, there may be exceedingly marked disease, and the ovarian and tubal complications small. Here it is well to remember that intestinal complications are often at the bottom of the size of the tumor, so that when adhesions are all freed, the mass that is to be removed is insignificant in its appearance, though examination by floating the mass will disclose the multiplicity of the adhesions and their density. Tubercular variety of inflammation is often puzzling and should receive careful attention.

In all forms of inflammation under consideration, the tendency is toward deposits in multiple locations. This is due both to inflammatory strictures in the tube and to the different structures encountered in the inflammatory process. Hence it is necessary to deal with all pelvic deposits as we know they must exist anatomically, taking into consideration their cause and the structures involved, and not treat them as hypothetical quantities under uncertain processes. If we consider the suppurating, inflamed tube as an offending organ, quite as much as the retained placenta, we cannot go astray in its treatment. It is just as logical to treat the remaining *débris* of labor as a benign and inoffensive residue, as to look at this internal disease as harmless; indeed, it is much more rational, for the one has some chance of escape, the other none.

ON THE TORSION OF ARTERIES.

In connection with operations for excision of tumors, and other excisions of a like character, Jonathan Hutchinson remarks as follows: "I may mention that for many years I have quite ceased to use any other means for the arrest of arterial bleeding than torsion. In excision of the breast, for instance, I do not think that I have during the last fifteen years ever used a ligature. The torsion is always effected by a pair of Well's clamp forceps, now in such universal employment. I am always extremely careful to close all vessels, keeping the wound exposed for a considerable time for that purpose. Very seldom, indeed, have I encountered any secondary hemorrhage."

—*Columbus Med. Jour.*

PLAIN TALKS ABOUT EARLY DIAGNOSIS, AND EARLY OPERATION IN CERTAIN INTRA-PELVIC DISEASES OF WOMEN.*

By CHAS. A. L. REED, M. D.,
CINCINNATI, OHIO.

The author opens this subject with the important remark that, "the chief cause of mortality in abdominal and pelvic surgery may be epitomized in the word 'delay.'" The patients themselves may be often to blame, either through undue modesty or fear instilled by friends or physicians who misapprehend the true status of pelvic surgery. What is needed to remedy this evil is to have the actual results of special workers in this field of surgery published and republished, until the general profession begins to comprehend what can be done for the relief of their unfortunate patients. It should be held up that the mortality of abdominal section in skilled hands is under three per cent, and that with all operators, results improve just in proportion as they get their cases early and as their experience increases. The doctor further emphasizes that he insists upon examination only in the presence of persistent symptoms pointing to disease in the pelvis; the word "persistent" being significant in that it implies that the conservative measures of treatment have first been tried; he does not operate upon twenty-five per cent. of the cases that come to him for that purpose, and never selects cases. He feels certain his colleagues are equally discriminating.

In making examinations he does not agree with the writer in Mann's system of gynecology, that inspection of the external genitalia is as indelicate as unnecessary, and should never be practiced in the absence of some special indication. He condemns the Fergusson's cylindrical speculum, blaming the tortures induced by this instrument, for some cases never passing beyond their first examination. The sound, to-day the opprobrium of the gynecic outfit, often produces great mischief, never aids in diagnosis should be discarded entirely. All grotesque and

*Read before the Med. Soc. of Erie County, June 14, 1892.

needless postures frequently pictured in the books are condemned.

For an operator of experience, whose touch is cultured, it is not necessary to place the patient in any other than the recumbent posture with knees flexed. A speculum has no place in the diagnosis of conditions above the pelvic diaphragm; instrumental examination of the uterine cavity is always hazardous; should be employed only in exceptional cases, and then only under the most scrupulous aseptic precautions.

Tumefaction above either fornix with or without fixation, generally means irreparable organic mischief, which, if not already furnishing a nidus for pus, offers at least an inviting field for suppuration. When this condition exists in connection with a history of previous miscarriages, dirty accouchements, intrauterine thickenings, and electrical treatments, but particularly when a distinct history is given of one or more attacks of pelvic peritonitis, which, however, may not have been of a severe type, the conclusion is simply irresistible that the case belongs in the surgical category, and that operation should be advised and practiced at the earliest possible moment.

RETENTION TUMORS.

Retention tumors in the abdomen formed the subject of some remarks by Jonathan Hutchinson in the *Archives of Surgery*. He described several cases of remarkable retention of feces in children and stated that this condition is the common cause of pot belly. There is no obvious retention in these cases he says, the bowels perhaps moving regularly or even incontinently, producing precisely the same condition of things which, when it occurs to the bladder, is described as "retention with incontinence." He says that he once tapped a woman's belly and drew off urine where he evidently expected to find ascites. For the recognition of abdominal retention tumors he offers the following memoranda:

(1) The distension, although enormous, is usually quite painless.

(2) The retention is never absolute, but only residual. There is always overflow.

(3) The patient never assists the surgeon, but rather misleads him, insisting that there is free relief of bowels and bladder.—*Lancet*.

THE PRACTITIONER'S ANATOMY OF THE RESPIRATORY PASSAGES AS APPLIED TO INTUBATION, LARYNGOTOMY, TRACHEOTOMY AND BRONCHOTOMY.

A paper with this title was read by Dr. James E. Kelley, (Section Ped., N. Y. Academy of Med., *Virginia Med. Monthly*, vol. xviii, No. ii, 1892) and illustrated by charts, diagrams and elaborate fresh dissections. Especial attention was given to the mechanical view of the subject, as being of far more value than the vast amount of detail to which the student is treated without a clue to its practical application.

The anatomy of the child varies but little from that of the adult. The *thy-mus* is the only structure that causes important modification in the region under consideration. In operating low down in the pre-tracheal space in young children, it causes serious obstruction. It varies greatly in shape, and is subject to numerous anomalies. It usually forms a body extending entirely across the space between the sterno-mastoid muscles. Two processes pass upward in close apposition to the tracheal fascia and terminate within half an inch of the isthmus of the thyroid to which they are attached by two ligamentous bands. Hence, but a limited portion of the trachea is uncovered and available for operation below the isthmus of the thyroid. This latter body is occasionally absent, and sometimes in an abnormal position—conditions which may be very puzzling to the operator.

It is impossible to make a dissection in this region as neatly and almost as bloodlessly in the living subject as in the cadaver. This is especially true in young patients. The more closely an operation resembles a dissection, the more satisfactory it is to the surgeon, and safer for the patient. Hap-hazard surgery is a lottery, in which fools play for their patients' lives.

In considering the anatomy of the region, the relations of the osseous structure are of much importance. The posterior surface of the larynx and trachea corresponds and adapts itself very closely to the contour surface of the spinal column. The œsophagus and lower portion of the pharynx, which occupy but little space,

are the only structures between the trachea and the vertebrae. Thus the laryngo-tracheal tube, passing downward and backward, intersects the place of the sterno-mastoid muscles. This is a point of much practical importance in *low tracheotomy*.

Laryngotomy is an operation so undesirable that it merits but little attention. It opens the larynx just below the rima glottidis, where the canal is narrowed into a wedge, the thin edge being anterior. The cartilage is rigid, and of such low vitality, that the injury resulting from the separation, and the introduction of a tube, is liable to be followed by necrosis. There being but little subcutaneous tissue, an unsightly scar usually results, which lies so high that it cannot be concealed.

The hybrid operation, *laryngo-tracheotomy*, is unjustifiable, as it destroys the continuity of the cricoid cartilage upon which the larynx largely depends for its shape. All the external operations upon the respiratory passages are performed between the hyoid bone and the sternum, in the mesial line, between the sterno-hyoid and the sterno-thyroid muscles, but tracheotomy alone being done *below* the isthmus of the thyroid. Not an important structure lies above the isthmus, but below there are numerous important vessels. This lower space is analogous to a space just above the pubis. Two spaces are formed by two distinct layers of fascia, which are fused above the isthmus to form a single fascia. In the superficial space, are the anterior and transverse jugular veins, and a few small arteries. In the deep space are the left innominate, the inferior thyroid, and a venous plexus.

Much interest has, of late, been aroused in the operation of *bronchotomy* for the removal of a foreign body from a bronchus. The author is inclined to think that the operation is justifiable, and that there is no insuperable anatomical difficulty in the way. The cordate shape of the chest places the root of the lung much nearer the surface than is usually supposed. A vertical incision should be made through two or more costal cartilages, or through the ribs just internal to the mammary glands. This readily brings the structures into view, the relations of which are very close and intricate. While the mechanical difficulties are great, a still more important question is the possible effects of interference with the heart and great

vessels. Upon this point little or nothing is known. While *intubation* requires but little anatomical knowledge there are certain points which are quite essential. The point of the tube may enter numerous depressions and fossæ, preventing its introduction. The first are the glosso-epiglottic fossæ, separated from each other by the frenum of the epiglottis. The glottis itself is situated in the midst of soft, yielding tissues, which are easily indented.

A slight depression exists just above the false vocal cords which may readily catch the tube. The lateral ventricles of the larynx are, however, the source of most serious trouble. These ventricles lie upon either side between the true and false vocal cords. The true cords especially in phonation or stridor approach more closely to the mesial line than the false, thus forming a cavity with a concave floor, in which the end of the tube is very easily entangled. Just behind the glottis, and separated from it by the arytenoid bodies is the lower portion of the pharynx, the most capacious snare set for the operator, and the one into which he most frequently falls. The whole area in the infant is readily covered with the tip of the index finger. The surface of the glottis is moreover, very oblique to the pharynx, so that the tube easily glides backward into that cavity. Unless the true cords are accurately reached, the point of the tube is deflected into the capacious and yielding ventricle.

The operation can, therefore, be performed with facility only when the tube is held parallel with the mesial line of the body, but obliquely to the long axis of the rima, and with the point directed toward the inferior margin of the cricoid cartilage. This can be effected by introducing the instrument into the mouth with the handle over the bicuspid tooth, with the point of the tube directed forward toward the glottis. The common error is thus avoided of passing over the epiglottis. Owing to the more extended area opposed to the ventricles, the tube is not so liable to be caught in them. As the surface of the larynx containing the glottis does not look upward, but almost directly backward, the handle of the introducer should be elevated to bring the point of the tube forward.

In young children the epiglottis is sometimes so soft and small as to be found with great difficulty. Pass the finger low

into the pharynx until the resisting cricoid cartilage is felt, on the upper margin of which are situated two movable nodules, the arytenoid cartilages. Immediately above, and in front of these in the mesial line, is the epiglottis.

Dr. H. D. Chapin said that he had performed tracheotomy several times upon children under two years, and had been surprised at the extreme obliquity of the trachea which caused it to lie at the great depth at the lower portion. This was a strong argument in favor of intubation in young children instead of tracheotomy.

Dr. Kelly remarked that he believed that the narrowest point in the respiratory tract was at the true vocal cords.

The Chairman referred to experiments by Dr. O'Dwyer and himself, which proved that the narrowest point was not at the cords, but at the cricoid cartilage. An intubation tube could frequently be drawn, with the use of but little force, downward past the cords, which could not be made to pass below the cricoid. A tube much smaller than the prescribed size might drop below the cords, but would not pass below the cricoid into the trachea. The most recent modification of the tube approved by Dr. O'Dwyer, consisted in making the lower end bulbous in shape and equal in size to the largest part of the tube. This would prevent its entering the ventricle of the larynx, a very frequent source of failure.

Dr. Kelly replied that if the tube were turned to the side as far as possible during the introduction, it would bring the long diameter in position to act as effectually as the bulb described. The posterior operation of bronchotomy was impossible because of the closer apposition and less yielding character of the ribs requiring extensive resection. The trunk of the intercostal vessels were also met posteriorly instead of the branches.—*Pacific Med. Jr.*

TREATMENT FOR SWEATING HANDS.

Take of tincture of belladonna, 1 drachm, eau de cologne, 1 ounce. Mix. Pour a few drops of glycerine into the palm of the hand, then add to it an equal quantity of the above mixture, then rub the hands together strongly. They should have been well washed in soft water and thoroughly dried previous to the application.—*American Analyst*, Oct. 15, 1892.

SURGICAL TREATMENT OF PERITONITIS.

Dr. C. J. Cullingworth read before the Obstetrical Society of London a paper based on fifty observations of his own, in favor of surgical intervention in certain cases of pelvic peritonitis. The cases include the whole of the author's experience to February, 1891. Pelvic suppuration was present in thirty cases, or 60 per cent. It occurred in the fallopian tube alone in thirteen cases, in the ovary in seven cases (in six of which tube and ovary were in direct communication), while in the remaining four cases the seat of suppuration was either not precisely determined or did not involve either the tube or the ovary. There was strong presumptive evidence of gonorrhœa in a large proportion of the cases, and in four cases the proof seemed complete. Nine of the cases died, a mortality of 18 per cent. Seven of the deaths were due to peritonitis, probably septic, one to acute nephritis, and one to collapse on the eleventh day. Of the fatal cases one was tubercular disease of the tubes, two were purulent salpingitis, one was double salpingitis with old hæmorrhage, two were suppurating tubo-ovarian cysts, one was retro-peritoneal suppurating cyst, two were old peritonitis with serous cysts of broad ligament. The mortality sensibly diminished as he acquired experience. Hæmorrhage to a greater or less extent, existed in twelve of the thirty-two cases of salpingitis. In five cases there was amenorrhœa, in three dysmenorrhœa, whilst in twelve the menstrual function was undisturbed. In sixteen cases the removal of the appendages was complete, in twenty-three partial. Of the former, fifteen recovered; of the latter, seventeen. The peritoneum was flushed in twenty-two cases, of which eighteen recovered. Drainage was employed in forty-seven out of the fifty cases. In two cases a fæcal fistula formed, which in each instance healed spontaneously. In five cases the patients complained some time after the operation of more or less persistent pain. A sinus existed in six of the cases when the patient left the hospital; in two of these it had not healed when the patient was last seen. In four cases a hernia had occurred in the line of incision. He particularly called attention to the unreliability of the temperature as a sign of the existence of pelvic suppuration, the

temperature before operation having been absolutely normal in twelve of the thirty cases in which suppuration was present. He suggested the following conclusions as the outcome of his experience. 1. Recurrent attacks of pelvic peritonitis in the female ought always to lead to a strong suspicion of the existence of chronic disease of the uterine appendages, and to careful bimanual examination. 2. Purulent collections in the pelvis are particularly apt to set up recurrent peritonitis, and are more common than is at first supposed. 3. Where distinct swellings are found in the posterior quarters of the pelvis, in connection with recurrent attacks of pelvic peritonitis, surgical relief is usually indicated, and generally speaking, the sooner such relief is afforded the better. 4. Purulent inflammation of the mucous membrane of the fallopian tube differs from purulent inflammation of other mucous membranes in the absence, owing to the anatomical situation of the fallopian tubes, of a natural outlet for the pus. A very slight amount of swelling of the mucous membrane suffices to block the tube at its uterine end, and if pus be present in the tube, it must then either remain pent up in the tube, or be poured out through the fimbriated end into the peritoneum in either case becoming a source of danger. 5. Salpingitis being a painless affection, the wall of a pyosalpinx may be on the point of perforation before an acute attack of peritonitis gives warning of the presence of serious disease. 6. It is safer to attack cases of pelvic suppuration from above than from below. 7. Suppurating tubo-ovarian cysts are usually the result of ulceration on the tubal side of the adhesion between tube and ovary, but in exceptional cases results from ulceration on the ovarian side. The immediate results are more satisfactory after complete than after partial operation. 8. One of the chief risks in the operation for the separation and removal of inflamed tubes is the liability to mistake thickened and adherent intestine for diseased tube. The way to avoid error is to trace the tube from its uterine end outwards. 9. The exceptional instance in which pain persists after operation for gross lesions of the uterine appendages are generally to be explained either by omental or intestinal adhesions, or by the co-existence with the actual disease of a neurotic condition, of which the pelvic pain is a

mere local expression. 11. Tubal disease in the virgin is generally, if not always, tubercular. 12. Hydrosalpinx, in the great majority of cases, is merely a form of retention-cyst due to occlusion of the distal end of the tube from without. 13. Simple collections of serum, both large and small are apt to form beneath the peritoneum covering the tube and broad ligament in chronic cases of pelvic inflammation especially in those of very long standing. Probably the best treatment of these cysts, after exposing them and making certain of the diagnosis by abdominal section, is simple puncture and evacuation, the risk of removing being, in the author's experience, out of proportion to their importance. 14. Hæmatosalpinx, though no doubt due, in the majority of cases, to tubal gestation with apoplexy of the ovum, is sometimes an incident in the course of a chronic salpingitis. In these exceptional cases the walls of the distended tube, instead of being attenuated by the distension, as Bland Sutton has shown them to be in tubal gestation, are thickened by inflammatory deposits.

The paper was illustrated by a number of drawings and photographs of the appearances in certain of the cases.

The discussion was adjourned until the next meeting.

IODOFORM.

Following are a few of the numerous applications of iodoform. In the obstinate, chronic enlargement of tonsils, so common in our changeable climate, the writer has derived good results from iodoform in pill of $\frac{1}{2}$ or 1 grain, three times a day, persisted in till patient declares throat is well. In glandular enlargements, particularly of a strumous nature, an ointment—20 to 60 grains to ounce of lard, vaselin, or lanolin—will prove a prompt and effective sorbefacient.

It has been found useful when applied to enlarged prostrate gland. A professional friend informs me that a prostate enlargement with stricture, that had resisted all other treatment, yielded to the local application of the drug. Writer has seen a small ulcer of leg to which a 20-per-cent. ointment was applied, rapidly fill up from bottom with healthy granulation. Large burnt surfaces have healed and cicatrized without contraction under its benign influence.—*American Therapist.*

Selected Formulæ.

BURNS.

Von Bardeleben recommends for burns of moderate severity the use of a powder of equal parts of subnitrate of bismuth and powdered starch. The burns are thoroughly cleansed, then washed with a three per cent. carbolic, or three per cent. salicylic acid solution. The blisters that are present are then removed under antiseptic precautions and the above powder then thoroughly applied. This is covered with layers of cotton, which are removed as they become saturated with the secretions, except the one next the wound. This dressing may remain undisturbed for one to two weeks or even a month. In most cases, pain disappears a few hours after applying the bismuth. In burns of the face the writer uses the powder with no other dressing.—*Boston Med. and Surg. Jour.*

INHALATION IN WHOOPING COUGH.

R	Thymolis.....	gr. xx.
	Acid carbolicis.....	
	Ol. sassafras.....	
	Ol. eucalyptus.....	
	Picea liquidæ.....	āā. f 3ij.
	Ol. terebinthinae.....	
	Etheris.....	f 3iv.
	Alcoholis, q. s. ad.....	f 3ij.

M. Sig.—Put about 30 drops upon a pad of such size as to be conveniently hung around the child's neck, renewing the application every two or three hours.

In severe cases the inhalation treatment is supplemented by the internal administration of:

R	Acid carbolic.....	gr. iiij.
	Sodii bromid.....	gr. lx.
	Tinct. belladonnae.....	gtt. xx.
	Glycerina.....	f 3ij.
	Aquæ q. s.....	f 3ij.

M. Sig.—f 3ij occasionally for a child of 3 or 4 years of age.

—*Jour. Amer. Med. Assn.*

GLYCERIN SUPPOSITORIES.

R	Sodium carbonate.....	40 grains.
	Stearic acid.....	80 "
	Glycerin.....	1,080 "

Sig.—Dissolve the sodium carbonate in the glycerin, add the stearic acid, heat carefully (preferably by the use of a water bath) until effervescence ceases; the solution is then poured into a suppository mold to make 13 suppositories.

There is no necessity for cooling the molds with ice, although there is no objection to this in warm weather. As each suppository contains about 90 per cent. of glycerin, they must be protected from the action of moist air, which has a tendency to liquefy them. Several expedients are resorted to. Each one may be

wrapped in tinfoil or quickly dipped in melted paraffin; or each one enclosed in a small glass vial without a shoulder and made for the purpose of holding one suppository.—*Pharmaceutical Record.*

COUGH MIXTURE.

R	Syr. tolu.....	
	Syr. pruni virg.....	
	Tr. hyoscyami.....	
	Sptæ. eth. co.....	āā. 3i.
	Aquæ.....	

M. Sig.—A teaspoonful every hour.

—*Janeway.*

For the treatment of the reflex cough accompanying catarrhal sore throat, there is no remedy so effective as a spray of the following, which may also be used as a gargle:

R	Acid carbolic.....	3i.
	Pulv. sodii bor.....	3i.
	Cocaine hyochlor.....	grs. xii.
	Glycerini purif.....	3ss.
	Aquæ rose.....	ad 3xii.

Sig.—To be used as directed.

—*Ontario Med. Jour., Oct., 1892.*

Dr. T. J. Mays (*Pitts. Med. Review*) suggests the following as a stimulant to the appetite in Pulmonary Consumption:—

R	Acid. phosphoric. dilut.....	
	Acid. muriatic. dilut.....	
	Acid. sulphuric. dilut.....	āā. f 3ss
	Tinct. ferri chloridi.....	

M. Sig.—Thirty drops in a half glass of cold sweetened water during meals

—*College and Clin. Rec., Oct., 1892.*

THE "SUN" CHOLERA CURE.

Take equal parts of tincture of opium, tincture of rhubarb, tincture of cayenne, spirits of camphor, essence of peppermint.

Mix well together. Dose: fifteen to thirty drops in water; to be repeated in fifteen or twenty minutes if necessary.

This is the original formula for the *Sun* cholera Cure. It was given to the *Sun* in the "cholera year" 1849 by George W. Busted, then and now a practicing pharmacist in this city. It was published daily in the *Sun* during the summer of that year. It was published at intervals for several years, and again daily during the "cholera years," 1855 and 1866, and has been printed in the *Sun* probably 1,000 times since it first appeared.

The *Sun* cholera cure has been adopted into the United States Pharmacopœia, and is a medicine approved and valued by every medical man in the country.—*American Analyst*, Oct. 1, 1892.

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THE MEDICAL AND SURGICAL REPORTER.

SATURDAY, NOVEMBER 5TH, 1892.

ANTIVIVISECTION.

For a number of years, in England and America, an antivivisection propaganda has from time to time attracted public attention.

Popular sympathy is easily aroused for any reform that is not aimed at popular crimes or vices. Public opinion indignantly resents abstract wrong or evil deeds in somebody else, especially when the heart is wrung by tales of "inhuman" and "diabolical" cruelties sobbed by women with streaming eyes or whispered with bated breath by men.

But justice is likewise an element of an enlightened people and after emotion has been gratified a desire is felt to hear what the other side may have to say. With sincerity which events have shown to be more apparent than real and with imagina-

tion fired by enthusiasm hot to melt the bowels of compassion, Zoophilists have prosecuted a campaign against experimental research.

With sincerity more real than apparent the energy expended to save a rabbit from inoculation would raise a fallen woman; imagination tempered with common sense would not perceive more horror in the breathing of an anesthetized dog than in the wail of a starving child. Fervent enthusiasm might be used to elevate the "submerged tenth," and with better results than when directed to the distortion and hindrance of efforts to aid humanity which time and experience have vindicated.

But the zeal of the anti-vivisectionists has over-balanced the wisdom, and enthusiasm far out-stripped the knowledge.

In this country at a recent congress the utmost the *zoophilistines* could accomplish was the passage of a compromise resolution in effect condemning all *unnecessary* experiments on living animals.

In England, speaking of the recent exposé of the anti-researchers, the *British Medical Journal* says:

The anti-research controversy opened at the Church Congress and which at one time threatened to extend itself to portentous proportions happily seems now likely to come to an early conclusion; and that in the fashion which must be wholly satisfactory to the profession since physiological experiment of the kind is absolutely necessary for the progress of human knowledge and the alleviation of human suffering. Miss Cobbe has fairly turned tail and quits the field. She does so under an excuse which very well accords with the system of tactics which she has throughout adopted in this matter. For a series of years, and in a variety of publications, this lady brought a series of vile accusations against the most eminent, humane, and accomplished physicians, surgeons, and scientists of the day, having charged men of the rank, class, and character of Lister, Burdon Sanderson, Lauder Brunton, Ferrier, Horsley and their supporters and defenders Paget, Clark, Humphry, Wilks—and in fact the whole medical profession with a few insignificant exceptions she has charged; the one with performing and the other with countenancing and defending, acts which she so

describes as to induce her ally in the attack—Canon Wilberforce—to describe them as “inhuman devils,” and the Bishop of Manchester to characterize them as “diabolical.” She now withdraws from the contest which she has provoked, because she finds it intolerable to be told, with abundant proof adduced, that her quotations are false; that she has deliberately suppressed the fact that in the very operations to which she refers morphine and chloroform were administered; and that she has repeatedly and fraudulently omitted to state that vital fact.

When her falsehoods are plainly exposed and she is challenged in very distinct language to bring her statements to proof—statements she has not attempted to prove and knows she cannot prove—to withdraw them in sackcloth and ashes, she replies through Dr. Berdoe that her feelings are too much hurt to allow her to take the only course which truth and honor and justice demand—that of humble, open, and lifelong repentance and humiliation.

It is, of course, open to Miss Cobbe to throw her literary assistant into the ditch, and to take for herself the credit of all the high moral indignation with which she fills her signed preface; and thus to leave her literary assistant to bear the dishonor of having deliberately suppressed the vital fact that in the very operations which are quoted in inverted commas as evidences of horrible cruelty, the animals were under the influence of chloroform or of chloroform and morphine. It is of little avail for her to do this, because in her preface she takes upon herself the whole responsibility of asserting that in every instance cited the presence or absence of anaesthetics has been carefully noted. If the fault, nay, the crime, of this suppression of truth on which such an edifice of deliberate, and persistent calumny has been built, be not with her but wholly with her assistant, let her at least express her profound regret at the deceit which has been practiced on her, and at having been led, in that case, unwittingly to have done a most cruel wrong. Thus far she has done nothing of the sort. She is a professed exponent of the laws of Veracity, with a big V, and no doubt the list of eminent persons who have been misguided by her, and induced to allow their names to be paraded as patrons of the Antivivisection Society, has relied upon her Veracity, and taken it to mean truthfulness. Let Lord Coleridge, Mr. Stansfeld, Mr. John Morley, the Bishops of Southwell, Liverpool, Wakefield, Carlisle, in addition to the Bishop of Manchester and Bishop Barry, let them one and all, come forward now and say honestly what they think of this exhibition of Unveracity. They, who are not

ladies, need not shrink back because a spade is called a spade; and if this thing is, as Professor Horseley had shown it to be, a falsehood of the worst kind, they need not be deterred from expressing their opinion, even though a “Saxon monosyllable” has been used to characterize the falsehood.

Book Reviews.

Gynecology, A Manual for Students and Practitioners, by G. W. Bratenahl, M. D., Assistant in Gynecology, Vanderbilt Clinic, New York, and Sinclair Tousey, M. D., Assistant Surgeon, Out-patient Department, Roosevelt Hospital, New York. Lea Bros. & Co., Philadelphia. Student's Quiz Series. \$1.00.

The authors have discussed the diseases of the female generative organs in the order of the anatomical position of the latter, beginning with the vulva; closely following the teachings of Emmet, Munde and Thomas. As a rule the symptoms of the different diseases and the various operations are clearly and concisely stated, with the exception of Emmet's operation for lacerated perineum, where the amount of denudation necessary and the manner of passing the sutures are not plain.

Some old fashioned notions still cling to the book, however, since pelvic cellulitis is gravely discussed and a differential diagnosis given by which the troubled gynecologist or busy practitioner may decide whether the case in point is one of pelvic peritonitis or cellulitis. The sound is still used as a diagnostic instrument though the contra-indications to its use are carefully stated. We notice, however, one glaring contradiction. On page 30 we are told that the sound is contra-indicated in “any peri-uterine inflammatory condition, or tenderness of the uterus and appendages;” and on page 32 we read that “it should not be used to replace a mal-positioned uterus or to test its ability,” yet in discussing flexions, we find under anti-flexion (page 105) that “the diagnosis consists in the establishment of the stability of the flexion. This may be determined by the use of the sound.” That “anteflexion might be mistaken for anterior inflammatory and cellutic exudations. The sound passed into the uterine cavity will determine these conditions.” Probably it will determine these, and also a subsequent section should its incautions use light up an old standing pelvic inflammation or tubal disease. Again, under

retro-flexion, we are told that the sound may be employed to correct the mal-position "when the uterus is too sensitive to be pushed upward by the fingers, but is always more or less unsafe." Surely this is an oversight which will be corrected in later editions.

The dangers of curetting the uterus in the presence of tubal trouble are clearly shown and also that of cervical dilators. In speaking of securing the pedicle in removal of diseased tubes and ovaries, we are told that it is best done by ligating with the Staffordshire knot. In view of the fact that this knot has proven treacherous so often, it would seem better to us that a simple figure of eight or chain ligature be advised.

Extra-uterine pregnancy is fairly well treated and immediate removal of a ruptured tubal gestation advised. In unruptured cases the treatment of delay and doubt by means of electricity is urged. Electricity is advised for acute inflammation, adhesions and exudates, and its use in gynecology thus summed up: "In a certain proportion of cases in the above classes the results are excellent; in other cases the results are discouraging. While not a panacea, it is still a legitimate and desirable means of treatment in gynecological diseases." The contra-indications to its use and its dangers receive no mention and we are led to believe that it is harmless.

The volume is what it pretends to be—a students' quiz-compend, and may be useful as such, a brief remembrancer to the rusty practitioner.

BOOKS RECEIVED.

Diseases of the Lungs, Heart, and Kidneys. By N. S. Davis, Jr., A. M., M. D., Professor of Principles and Practice of Medicine, Chicago Medical College; Physician to Mercy Hospital; Member of the American Medical Association, Illinois State Medical Society, Chicago Medical Society, Chicago Academy of Sciences, Illinois State Microscopical Society; Fellow of the American Academy of Medicine; Author of "Consumption, How to Prevent it and How to Live with it," etc. No. 14 in the *Physicians' and Students' Ready-Reference Series*. In one neat 12mo volume of 359 pages. Extra Cloth, \$1.25 net. Philadelphia: The F. A. Davis Co. 1231 Filbert Street.

Tuberculosis of Bones and Joints. By N. Senn, M. D., Ph. D., Professor of Practice of Surgery in Rush Medical College; Professor of Surgery in the Chicago Polytechnic; Attending Surgeon Presbyterian Hospital; Surgeon-in-Chief St. Joseph's Hospital; President of the American Surgical Association; President of the Association of Military Surgeons of the National Guard of the United States; Permanent Members of the German

Congress of Surgeons, etc. Illustrated with 107 Engravings (seven of them colored). In one handsome Royal Octavo Volume, 520 pages. Extra Cloth, \$4.00 net; Sheep, \$5.00 net, Half-Russia, \$5.00 net. Philadelphia: The F. A. Davis Co., Publishers, 1231 Filbert Street.

Hygiene of the Sick-room. A book for nurses and others. By William Buckingham Canfield, A. M., M. D. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. \$1.50.

Diseases of Women. A manual of non-surgical gynecology designed especially for the use of students and general practitioners. By F. H. Davenport, A. B., M. D. Second edition, revised and enlarged. Philadelphia: Lea Brothers & Co. 1892.

A Manual of Physics. Being an introduction to the study of physical science. Designed for the use of university students. By William Peddie, D. Sc., F. R. S. E. New York: P. P. Putnam's Sons. London: Baillière, Tindall & Cox, 1892. \$2.50.

The Ready-Reference Handbook of Diseases of the Skin. By George Thomas Jackson, M. D. (Col.) Philadelphia: Lea Brothers & Co. 1892.

Periscope.

THERAPEUTICS.

ON THE TREATMENT OF GAUCHER IN RELATION TO DIPHTHERITIC PARALYSIS.—ON THE CON- TAGION OF ANIMAL DIPH- THERIA TO MAN.

Dubousquet-Laborderie (*Jour. de Méd. de Paris*, 1891, iii., 510.) writes: Since 1884, Gaucher has treated or seen in consultation eighty-five cases of diphtheria. Among these he has seen but once a case of paralysis. Dubousquet-Laborderie, since 1884, has taken care of 127 cases of diphtheria, among which he observed only three cases of paralysis. All three cases were light. These 212 cases are grouped without distinction, but among the number, several have been diphtheria of very severe type. This showing seems to militate in favor of the efficiency of the treatment advocated by Dr. Gaucher—a treatment which arrests on the spot the rapid development of the microbes, and prevents the toxic products from being carried to the nervous centers.

Since the work of the commission appointed by the Academy of Medicine at the beginning of the century, to study in Cologne the contagiousness of the diphtheria of fowls for man, many reports have come to confirm the conclusions of the commission. Klebs records himself for the contagion. But this idea of contagion assumes for premises the identity of the

nature of the diphtheria of human kind and of animals, while the bacteriologists have not generally ratified this, for the reason that the microbes do not resemble each other. The researches of the laboratories can hardly weaken the clinical fact in the matter, however. Loeffler has stated that culture of bacilli from diphtheritic pigeons inoculated upon other pigeons, communicated to them the disease which became promptly general, while the same cultures produced in chickens only small lenticular ulcerations at the point inoculated, without any general infection. From this he concluded that the diphtheria of pigeons and that of chickens were not identical. Some observations tend to show that what is called the quinsy of animals may be equally contagious: Two children assist at the removal of the hide of a horse dead of quinsy; both children die of diphtheria, or which there was no other case in the neighborhood. An adult man removes the hide from a donkey which had died of quinsy, and dies himself of diphtheria. No other case of diphtheria in the region. In another instance, a large number of fowls died of diphtheria, several of which were devoured by pigs. One of the pigs having died of quinsy, its owner pierces the trachea in the presence of a little girl of five years of age. This child succumbs to diphtheria, her sister is attacked also, but recovers. The place where this family lived was thirty kilometers from the nearest settlement, and no communication, direct or indirect, had never been noted in the place.

SEVERE ACCIDENTS OF IODISM.

An unsigned paper in *La Semaine Médicale*, 1892, No. 5, p. xviii, gives an excellent account of our present knowledge upon this subject. Oedema of the glottis, of the same kind as serous infiltration of the eyelids, has easily caused death. In instances when at death the body has been covered by a pemphigus, a nephritis has generally been found. At times, even when death has resulted from oedema of the glottis, this renal condition has not been found. Curiously enough the doses which have been followed by oedema of the glottis have been, in general, small (six and one-half grains, Fournier). Attempts have been made to avoid such symptoms as oedema, coryza, headache, conjunctivitis,

and epiphora, by its exhibition in milk, or the administration with belladonna, or bromide of potash. Following the method of Röhmman and Malachowski, it is believed that the bicarbonate of soda will prevent these untoward symptoms, by rendering the blood more alkaline, which will hinder the setting free of the iodine of the iodide of potash. It is given in two daily doses to the amount of seventy to ninety grains. In all cases the integrity of the renal filter should be assured, although even in actual renal disease, as chronic interstitial nephritis, we may receive great benefit from this drug. While disease of these organs is not an absolute contraindication, yet it should be administered in the usual (not small) doses, and at the outset, preferably with the bicarbonate of soda.—*Amer. Jour. Med. Sci.*

INTUBATION IN TUBERCULOUS LARYNGITIS.

Hopkins (*N. Y. Med. Journ.*) briefly mentions all the cases known to him in which intubation has been performed for the relief of dyspnoea due to tuberculous laryngitis, namely, three cases by Massei, who stated that stenosis might be got to yield in a surprisingly short space of time; a case by Dillon Brown, and another by Cox, both performed to procure euthanasia; and one case of his own. This was a woman, aged 39; after some months of gradual encroachment on the lumen of the larynx by the tuberculous process, she began to suffer from suffocative attacks, and when called to her Hopkins found that the dyspnoea was extreme, preventing sleep and swallowing. The rima was narrowed and the cords fixed owing to a mass of thickening in the posterior commissure. After failure with a large (largest for child of twelve) O'Dwyer's tube, a size smaller was passed after overcoming much resistance. The relief was immediate and considerable. The tube was expelled during a fit of coughing, but the relief to the dyspnoea persisted. Examination of the larynx showed that this was due to a portion of the mass in the posterior commissure having been torn away; some cicatricial process appears to have occurred later, still further enlarging the rima. She had an attack of dysphagia twenty-four hours after the intubation, and expectoration became blood-stained.

The condition of the patient, however, was materially improved; she regained appetite, was able to go out, and for the remainder of her life—about ten weeks—she had no recurrence of the dyspnoea.

Creasote, in doses of 4-19 drops daily, has produced good results in the hands of Dr. T. Valentine in *diabetes mellitus*.

Hot water, by enema, has been warmly recommended as a hæmostatic in *post-partum hæmorrhage*, or in threatened *abortion*.

Camphoric acid in 2 per cent. solution, applied on a cotton tampon, is reported as affording prompt and permanent relief in *acute coryza*.

Salicylic acid, while formerly condemned as a *diuretic* by most authorities, is now warmly recommended as such.

Euphorbia-pilulifera tincture (15 drops every two hours) is lauded as being very efficacious in all forms of acute "*cold in the head*."

Calcium sulphide in 1-20-grain doses is reported to prevent the formation of *boils*, and in $\frac{1}{4}$ -grain doses to hasten their supuration.

Ammonium acetate, in 15-grain doses, is reported to have given excellent results in *scarlatina*.—*Merck's Bulletin*.

POISONING BY ANTIFEBRIN.

During the last influenza epidemic in Sweden, a great many cases of poisoning by antifebrin were observed. This was due to a very prevalent, careless use of the drug without a doctor's prescription. Although somewhat severe symptoms were observed in many cases, all ended in recovery. In one case, reported by Dr. W. Warfring, a man aged thirty-five took two drachms of antifebrin. The principal symptoms observed in the order of their occurrence were a sense of fatigue and a feeling of weight in the head, coming on in five minutes; soon followed by a sensation of black and red clouds before the eyes; then sleep, from which the patient was easily aroused. On attempting to rise, he appeared like one drunk, fell down

and became unconscious. This was soon followed by a comatose condition, cyanosis, relaxed muscles, cold hands and feet, lowering of temperature, respiration and pulse. These latter improved after hypodermic injections of camphor and ether, but the comatose state continued for sixteen hours. The symptoms on the next day were frontal headache and cyanosis. The urine was clear, deep-colored, and contained much indican, otherwise normal. Some cyanosis remained on the third day, and the urine still contained an excess of indican. Another case was that of a girl of fifteen, who took nearly half an ounce of antifebrin. In a quarter of an hour her whole body became hot and perspiring. Vertigo, impairment of sight, and unconsciousness followed. This last condition continued for seven hours and a half. There was vomiting. Coma was not so deep as in the other case; cyanosis was well marked; pupils slightly contracted, temperature slightly subnormal. This patient recovered more speedily than the other, probably because the stomach was washed out within an hour after the antifebrin was taken. Similar, though not so severe, symptoms have been observed in other cases; the doses taken being, in one case, two scruples on two consecutive days, in two others two teaspoonfuls each, in one dose.—*Boston Med. and Surg. Jr.*

CRANBERRIES IN RHEUMATISM.

Dr. J. Hermann (*Wiener med. Presse*) speaks very highly of cranberries in the treatment of rheumatism, both acute and chronic. This berry has long been employed in popular medicine as an anti-rheumatic remedy. The writer has a case of chronic rheumatism which had resisted the salicylates and all the ordinary remedies. The decoction of cranberries was given, and after a few weeks a striking improvement set in, which was followed by a complete recovery in two months. The remedy was also tried in nine other cases, of which six were acute and three chronic. All these had been treated in vain with the salicylates and the various preparations of iodine, as well as with warm baths. The berry was employed in the form of a decoction, thirty to sixty grams of the entire plant—leaves, stalk and root—to 180 grams of water. This is drunk in twenty-four hours. The duration of

of the treatment was from one to three months. Out of the nine patients, seven were cured, while in two the remedy failed. In all the nine cases a slight diuretic effect was noticeable. It is advisable to continue the use of the decoction for some time after the disappearance of the symptoms, in order to prevent relapses.

SURGERY.

CONSERVATIVE SURGERY FOR NASAL OBSTRUCTIONS AND DEFORMITIES.

In a demonstration in the nose and throat clinic (*Post-Graduate*, New York), Dr. Clarence C. Rice emphasizes the following points in relation to conservative surgery for nasal obstructions and deformities:

1. The only way to become skilful with instruments of examination and expert in diagnosis is to personally examine the upper respiratory tract of as many patients as possible.

2. Cases for operation on the nose should be selected only after careful deliberation, and the relation in size between the obstruction and the total capacity of the nostril should be considered. When in doubt about the necessity for operation, try for a time treatment by topical application.

3. There are many cases of so-called "hypertrophic rhinitis" where the apparent hypertrophies are nothing more than erectile tissue distended by blood or serum, and many of these do not require the application of any destructive agent. The effect of a weak solution of cocaine upon these will aid in the diagnosis.

4. Remember that we do not find advanced hypertrophic changes in young people. The soft tissues are nearly normal, so it is not wise to injure the physiological tissue by operative procedure.

5. Deformities of the nasal septum are usually the first pathological condition to appear, and are the cause of the later changes in the soft structure of the nose. The removal of this septal lesion should first claim the attention of the operator.

6. Do not produce by operative measures large ulcerations on the septum, if they can be avoided, as there may be present in the case some constitutional vice, and therefore the ulcerations will be healed with difficulty. Nothing is more

efficacious in their treatment than the use of antiseptic washes and covering.

7. A "traumatic" atrophic rhinitis can be produced by destroying too much of the soft tissue of the nose.

8. When hypertrophic enlargements are present on both the anterior and posterior ends of the turbinated bones, reduce the anterior bones first, and the posterior ones will usually disappear without cautery application. The treatment of these by sedative and protective oily sprays may accomplish so much that the application of acids or cautery will not be required.

9. Use the galvano-cautery by inserting the pointed wire into the turbinated hypertrophy rather than by burning the mucous surface with the flat electrode.

10. Too much care cannot be exercised in the use of antiseptic solutions, both in preparing the nose and instruments for the operation, and also during and after the operation, until all ulceration is healed. Without the use of antiseptics the patient will surely suffer from sepsis.

THE OPERATIVE TREATMENT OF INTUSSUSCEPTION.

Hutchinson (*Arch. of Surgery*) says that the rule of practice in the early stages of intussusception ought to be invariably to try insufflation and injection, and it is only when they have failed that laparotomy ought to be thought of; they are not without risk, and must be tried with judgment and caution. There is no reason for preferring insufflation to the injection of water; for the latter he prefers hydrostatic pressure to the use of a syringe. In infants under two years of age laparotomy is so uniformly fatal that it should not be resorted to. Above that age, if injection has failed, a prompt resort to laparotomy should be recommended. It is desirable that this should be done early before the serous surfaces have become adherent. In the operation the chief difficulty is in releasing the incarcerated part. This is best done by pressure from below, not by traction from above. The older the patient the slower will be the progress of symptoms, and the longer the period during which it is possible to effect relief by operation. In adults a successful operation is possible even after a very long interval.—*British Medical Journal*.

MEDICINE.

PYORRHEA ALVEOLARIS.

M. W. Swartz (*Dental Review*) says: Pyorrhœa alveolaris, or Rigg's Disease, is first indicated by an uneasy sensation; then inflammation of the margins of the gums; looseness of the gums about the teeth, which form pockets; necrosis of edges of alveolar processes; a tendency to hæmorrhage, inflammation extending deeper into the gums; small sulci filled with pus; looseness of the teeth and change of position of the same; disagreeable taste; peculiar fetor of the breath; dark livid color of gums, with thick margins, and often extremely sensitive to the touch; in some cases the gums are denuded of their epithelium, with a polished appearance, in others with a pimpled surface; the teeth, at length, held in their cavities by a tough ligamentous attachment, due to the change occurring in the peridental membrane. A simple form of this disease may manifest itself at the gum margin, indicating its presence by a congested appearance, beneath which may be found a granule of calcified material. While in many cases there is a general congestion of the affected gum, and a proneness to hæmorrhage; in other cases the gum may present an anæmic appearance—pale and bloodless. This disease may also be associated with syphilis, mercurial salivation and scurvy. The deposit of salivary calculus and calcified substance is supposed by some to be secondary to this disease, as a deep red and denuded gum about the necks of the teeth may be present without any deposit. Yet in the vast majority of cases, this diseased condition is traceable either directly or indirectly to calcic formations about the neck and roots of the teeth.

First of all in any given case, completely remove all deposits from the teeth. - Have no fears as regards the hæmorrhage of the gum during this operation or any part of this treatment of these cases. In practice I have found that free hæmorrhage in advanced cases seems to prove a benefit rather than a detriment. Also that when the gums become more or less lacerated during the removal of the deposit from the roots, the condition seems rather to promote a healthy condition than otherwise. However, considerable care should be exercised during this operation, for upon the extent to which the gums will be restored

to their natural height and position about the root of the tooth, depends the condition of the remaining portion of the peridental membrane. And in fact it is quite as necessary to preserve the peridental membrane for this purpose, as it is to preserve the periosteum while operating upon diseased bone.

For an injection into the pockets after the removal of the deposit, I am partial to the use of peroxide of hydrogen. When it cannot be obtained fresh, I use a solution of carbolic acid, from two and one-half to ten per cent, or any of the other good antiseptics or disinfectants. For the purpose of injecting I employ a Dunn's syringe where the pockets are not very deep. When the pockets are deep, I employ the ordinary metallic syringe. I usually prefer it as one can then apply force enough to thoroughly wash out all foreign matter from the pockets.

After thoroughly injecting the pockets, absorb with absorbent cotton all moisture about the tooth to be further operated upon. And then by the use of a piece of soft pine wood cut in form of a tooth-pick, force into the pocket, its full distance, finely pulverized fresh cupric sulphate. For this purpose I employ nothing else. This operation will likely cause considerable pain, but never mind that. Heroic treatment is demanded. And if this operation is thoroughly performed at first treatment, in many cases nothing further need be done than the injection of the antiseptic and disinfectant. I am not in favor of too frequent treatment of these cases. And unless the case in hand is far advanced, I advocate the lapse of five or six days between treatment. Of course in the meantime I have the patient use some good antiseptic and disinfectant wash, alternately with a wash that tends to toughen and harden the gums. And in many of the milder forms of this disease after the removal of the deposit, I confine myself strictly to the employment of washes, and the results attained in almost every instance are very gratifying.

The washes I direct the patient to use are antiseptic and astringent in character.

VARIETIES OF VERTIGO.

Dr. Charles K. Mills (*Philadelphia Polyclinic*) says: No classification can be made to include every form of vertigo not

directly the result of labyrinthine disease, but the most important varieties are:

1. Vertigo dependent upon intracranial disease, chiefly tumor and pachymeningitis, but not including under this general head the disturbances of equilibrium arising from disease of the cerebellum or corpora quadrigemina. The three most frequent general symptoms of intracranial tumor are headache, nausea or vomiting, and vertigo; and these are commonly dependent upon the same mechanism. Most cases of brain tumor originate in the membranes of this viscus; the trigeminal nerve has a wide distribution in the dura, and intense localized irritation of its branches gives rise directly to pain and indirectly to nausea vomiting and vertigo. The deep nucleus of this nerve is closely related in position to the nuclei both of the pneumogastric and the auditory nerves, and the reflection or irradiation of powerful impressions from the former to the latter will cause vomiting and vertigo.

2. Ocular vertigo, which may spring from several conditions, but is most commonly due to serious disorders of refraction, to paresis or spasm of the ocular muscles, or to excessive retinal irritation. In any case the cause of which is obscure, the eye should be carefully considered and its defects corrected. Partial tenotomies and exact corrections or re-corrections with glasses have been found efficient, particularly in some of the milder but none the less annoying vertigoes.

3. Vertigo due to disease of blood-vessels, as anterior-sclerosis, from alcohol, syphilis, gout, old age, etc. The diagnosis of these cases is to be made by excluding carefully ear, brain, eye, severe local disease anywhere, toxæmias, etc., but chiefly by a careful examination for arterial or arterio-capillary fibrosis and the accompanying conditions of the heart, kidneys, liver and other organs. Reedy, resisting arteries, excessive aërus senilis, changes in the pulse rate, reduplicated or clanging cardiac sounds, and other well-known phenomena, will be present.

4. Vertigo which has its source in the state of the blood, under which general head are included those forms of the affection arising from anæmia or hyperæmia, lithæmia, and a large variety of toxæmias; and from the direct action of drugs and poisons.

5. Vertigo dependent upon intense irri-

tation reflected to the labyrinth or brain from more or less distant regions of the body—commonly classed as nasal, pharyngeal, laryngeal, gastric, intestinal, hepatic, uterine, ovarian, etc. The reflex origin of these vertigoes is often doubtful; they are more probably due to a toxic state of the blood, which is produced in various ways.—*American Lancet.*

A NEW TREATMENT FOR PHTHISIS.

De Renzi (*Riv. Clin. e. Terap.*, No. 6, 1892) publishes a new treatment for phthisis, consisting in the use of iodine internally in the following form:

R	Aq. dest.	1000 gra.
	Iodine	1 gr.
	Pot. iod.	3 gra.
	Sodium chlor.	6 gra.

This was first injected into the ear vein of healthy and tuberculous rabbits, and into the subcutaneous tissue of dogs, rabbits and guinea-pigs. Complete tolerance being established, he tried the remedy on phthisical patients. Hypodermatic injections were first given, and as much as 100 grains were given; these were not, however, well borne, so the drug was then given by the mouth, using from 500 to 550 grains. Nineteen patients, nearly all with advanced phthisis, were thus treated. In all, the treatment produced increased appetite and increased flow of urine. Symptoms of iodism arose in a few instances, but disappeared on leaving off the treatment. The author is of opinion that the results of this treatment will compare favorably with those of any other at present tried; the body-weight increases, the number of bacilli diminishes in the sputum, and the temperature is reduced to normal.—*Med. Age.*

HAY ASTHMA.

Dr. Edward S. Blair has treated a girl of ten years who for one-half of her life had been subject to annual attacks of this disease. Under the use of potassium iodide and grindela robusta there were slight catarrhal symptoms, but on lying down marked wheezing and dyspnoea. These symptoms were checked entirely by the fluid extract and euphorbia pilulifera [dose not stated], and the relief of these symptoms were followed by a marked increase in flesh and strength.—*Canadian Prac.*

GONORRHOEAL RHEUMATISM.

Dr. Brodhurst advises, as treatment for gonorrhoeal rheumatism, that the affected joints be wrapped in lint covered with mercurial ointment, that they should be bandaged as firmly as can be borne, and that the patient should be brought rapidly under the influence of mercury, preferably by inunction. With such treatment, pain and swelling quickly disappear and the joints resume their normal condition. At this stage passive motion should be instituted to ascertain if the motion of the affected joint is free, for lymph will have been deposited on the synovial-membranes through which adhesions form. These bands soon become firm and resist any attempt the patient can make to move the joint.

This treatment, according to the author, never fails if resorted to at the onset of the inflammatory stage. The knee, the hip, the elbow, and the shoulder are most frequently affected by this form of inflammation. Ankylosis may result—not in one joint only, but in every articulation of the body. When, after inflammation has ceased and passive motion has not been employed, adhesions remain and become firm, force is needed to restore mobility. This should always be used in the direction of flexion, since when thus employed no injury can accrue to any structure. Under some circumstances division of the flexor muscles is necessary. —*Therapeutic Gazette*.

METHYL VIOLET IN DIPHTHERIA.

Jaenicke (*Therapeutische Monatshefte*,) reports a number of experiments upon cultures of Loeffler's bacillus with methyl violet, and a few cases of pharyngeal diphtheria, in which he has used local applications of the substance. The number of his cases has been too small from which to draw conclusions, but in one or two days he noticed a fall of temperature, with coincident return of strength and appetite. He directs that a probe be covered with cotton and moisture in a saturated watery solution of methyl violet, and applied with considerable pressure to the membrane until it is colored a deep blue. In from two to five hours, when the color has disappeared from the membrane, a second application must be made. In cases where

there is septic intoxication necessarily the local use of the methyl will not save the patient, but by its energetic use on new membrane he thinks it will prevent its further development. He has never noticed any bad results, either local or general. He concludes his article as follows: "Methyl violet recommends itself as a curative medicine for diphtheria.

"(1) Because it has an especially antiseptic action on Loeffler's bacillus. Its power of preventing the growth of the bacillus being greater than its power of killing the bacillus, the application of the substance should be repeated as soon as the diphtheritic membrane loses its blue color.

"(2) Because it remains in the pseudo-membrane as well as in the mucous membrane of the mouth for an unusual length of time, and its antiseptic power is thereby increased.

"(3) Because it is relatively less poisonous than other materials heretofore used." —*Univ. Med. Mag.*, Sept., 1892.

SILVER NITRATE IN DIPHTHERIA.

Dr. Pilière, of Paris, has since two years been treating diphtheria by means of swabbing the throat morning and evening with a cotton tampon saturated with a 1:30 solution of silver nitrate. He rubs the affected parts pretty briskly, so as to detach the false membranes; then the throat is sprayed with a 1:300 solution of corrosive sublimate, in children above two years of age, and with a 1:1000 solution in younger children—the spraying being repeated every two hours during the day and every three hours of the night. It is stated that no untoward effect is produced by this treatment, and that the diarrhoea which might occasionally occur will disappear of itself.—*Ex*.

INFECTIOUS ERYTHEMA IN DIPHTHERIA.

Mussey's *These de Paris*, 1892, treats of this subject. There are several kinds of erythema more or less constantly present in diphtheria—the polymorphous, the rubéolic, the scarlatinoid, and the desquamative scarlatiniform. Often these are transitory. Some are difficult to recognize, as purpuric erythema. Such eruptions are of graver import in regard to prognosis when occurring late in the disease.—*Ex*.

OBSTETRICS.

THE CORROSIVE SUBLIMATE DOUCHE.

A French physician, in a recent article on the use of the corrosive-sublimate douche in lying-in women, cites thirty cases of death due to poisoning caused by the drug employed in this way. In the fatal cases, the strength of the solution was 1 to 1,000, or over, in ten instances; 1 to 1,500 in two; and 1 to 2,000 in the remainder. The absorption of the poison, the writer states, probably took place in the uterus at the site of the placenta. The symptoms observed were profuse diarrhoea with tympanites, vomiting, stomatitis, renal complications, pulmonary congestion, bronchitis, broncho-pneumonia; later on, circulatory disturbances, torpor, prostration, and collapse. The skin is either dry, or covered with cold and viscid perspiration; there is itching, which often precedes death; and, especially, a very peculiar and often generalized erythematous eruption. Lenticular spots also appear, which grow larger and of a deeper color at their periphery; they join together and form large blotches on the face, extremities, and trunk. The significance of this erythema is serious. It was often observed, shortly before death in cases where a cure had been looked for.

The writer concludes his article by stating that corrosive-sublimate must be used with "science and prudence in confinements, and that it is dangerous in inexperienced hands."

At a recent meeting of the Obstetrical Section of the New York Academy of Medicine, Dr. Von Ramdohr called attention to the danger of corrosive-sublimate douche, even in weak solutions. He said he did not see why physicians persisted in using it until a fatal case of poisoning came under their personal observation.—*Doctor's Weekly*.

RESULTS OF GONORRHOEAL INFECTION IN WOMEN.

Von Bosthorn, in the *Präger Medicin. Wochenschrift*, 1892, states that the prognosis of gonorrhoeal infection is favorable as long as the poisonous process does not invade the cervix. When this happens, rapid extension of the inflammation results, an "ascending gonorrhoea" causing

marked changes in the genital tract and surrounding tissues, with special preference for the endometrium and tubes. The dependent portion of the pelvic peritoneum also becomes involved. There may be latent gonorrhoea that is without acute stage, and insidious in its development. Later, this may become an ascending gonorrhoea with its adverse consequences. It is possible to cure the infectious disease itself, but the uterine catarrh and adhesions remain, starting up morbid processes at each menstrual epoch. In regard to accidents connected with the puerperal state, the author does not consider gonorrhoea as important a factor as Saenger does. In the acute stage applications of tannin and iodoform to the vaginal mucous membrane are recommended, and injections of bichloride of mercury, one part to one thousand. Cauterizations of the cervix with fuming nitric acid can also be employed, but intra-uterine medication is to be avoided. In the later stage of infiltrations, adhesions, and cicatrices that cause pain, according to the Thuer-Brandt method is of great value, together with the intra-uterine galvano-caustic. Observations based upon one hundred cases lead to the belief that removal of the tubes will always result in almost permanent freedom from pain. These cases have to be watched constantly after the operation, to insure the prophylaxis of ascending gonorrhoea.—*N. Y. Med. Record*.

NARCOSIS IN OBSTETRICS.

Dührssen (*Berlin. klin. Wochenschr.*) considers that an anæsthetic is of great diagnostic as well as therapeutic value. The patient (often much excited) can be kept quiet by a few drops of chloroform whilst certain important factors in labor are being ascertained, such as frequency of the foetal heart sounds. Primiparae are often very troublesome to explore, and it is then only by the aid of anæsthetics that the obstetrician can make sure whether the head has already entered the pelvic cavity. Narcosis is valuable for the timely diagnosis of occipito-posterior and transverse presentations. In explorations where the entire hand must be introduced into the uterus, anæsthetics are, of course, indispensable. For therapeutic purposes narcosis is needed for turning, especially combined external and internal version, for

detaching adherent placenta, manual removal of ovum and membranes in abortion, reposition of impacted tumors during birth, the management of prolapsed foot in breech presentation, and turning in incomplete dilatation of the os in multiparæ. In irregular contractions of the uterus chloroform often hastens labor. Sepsis is, in Dührssen's opinion, a contraindication for anæsthetics, and deep or long-maintained narcosis is dangerous in cases of eclampsia. It should only be induced, in such cases, to facilitate rapid delivery by operation. Tetanus uteri is also a contraindication. In acute anæmia a very little chloroform will take effect. When chloroform is given, Dührssen advises the obstetrician to get the patient well under, and then to leave the mask in the charge of the midwife, who must from time to time pour a few drops into it.—*British Medical Journal*.

GYNECOLOGY.

PERITONEAL ADHESIONS AFTER OVAR-IOTOMY.

Ovariectomy appears to be a somewhat more serious operation than we have of late thought it to be; for we are now learning something of the remote dangers which result from the adhesions of peritoneum and bowels formed during the convalescence from the ovariectomy. In the *Lancet*, September 10, Dr. Phillips of London, relates several fatal cases (one his own) in which such adhesions (found post-mortem) had caused death. We extract the report of one case, with Dr. Phillips' remarks on it:

Case 3 (Shively).—The patient was forty-five years of age; ovariectomy was performed four or five years before, since which time she has been constipated and has had periodic attacks of colic, which usually gave way to subcutaneous injections of morphia. She took a dose of cathartic pills one morning shortly before her illness began, and a good action had taken place; colicky pains, however, ensued in the evening. The pain increased and sickness began, but no tympanites appeared; long tube enemata were given repeatedly, but no further action took place. The vomiting and pain increased, and the patient died after several days' illness.

The post-mortem examination revealed

a complete key to the illness. "There were extensive adhesions of the intestines to the sides and posterior wall of the abdomen, binding them firmly down." This was doubtless the reason for the non-appearance of tympanites. A portion of ileum eighteen inches above the cæcum was adherent to and incorporated with the cicatrix of the wound of the previous ovariectomy. "Around the short portion, between this and the cæcum, a loop of small intestine was twice twisted, forming a kind of knot," and a complete occlusion was thus produced. The direct cause was doubtless the cathartic given on the morning of the commencement of the illness, possibly assisted by some favorable position assumed by the body.

We have therefore three distinct varieties of causation of intestinal obstruction after ovariectomy: (1) When the adhesion arises from the stump; (2) from the cicatrix of the abdominal wound; (3) from intestine to intestine. The small intestine, in consequence of its greater mobility, is liable to form adhesions with any abraded surface; hence we find them more common in connection with the small than the large intestine. Martin, of Berlin, has proved, as the result of observations on second operations on the same patient, the presence of slight non-septic peritonitis as the immediate effect of every ovariectomy. The colicky pains which patients often suffer from after ovariectomy, and complicated with constipation, are due to small peritonitic adhesions, the result of this localized non-febrile peritonitis. Hunter has devoted a paper to this subject and it is well worthy of perusal. If the prevention of formation of adhesions could be arrived at for forty-eight hours after operation, our position would be a more favorable one. In an interesting paper by Dr. R. T. Morris on this subject he declares that he has completely demonstrated the fact that an application of a film of aristol to the stump prevents secondary peritoneal adhesions; he experiments on rabbits and relates one case of abdominal section in the human object. The above facts seem to point strongly to the desirability of our knowing the subsequent histories of those patients whose cases fill the long lists of ovariectomies published from time to time and classed as complete successes.—*Maryland Medical Journal*, Oct. 15, 1892.

HYGIENE.

THE DIETETIC TREATMENT OF ULCER OF THE STOMACH.

Dr. F. Roux states that the treatment of this disease must not be based upon the principle of reducing the work done by the stomach to a minimum. The diet must consist of substances which are digested in the intestines, such as milk, eggs, farinaceous food, fruit, and green vegetables. Farinaceous foods play an important part in the treatment of gastric disease; together with eggs they should constitute the chief diet, but in order that they may not irritate the gastric mucous membrane they should be administered in a soluble form. Of potatoes, beans, and lentils, the meal of the latter is probably the best, as it contains a large amount of nitrogen and a quantity of iron equal to that contained in meat. Light puddings are nutritious, especially when made with eggs. Green vegetables are useful; carrots and turnips should be mashed; green peas and salads may be eaten; cabbage should be prohibited; fruits should be cooked, as they are not readily digested in the raw state. The single exception to this are grapes, which can be given at any time and in any quantity, especially if constipation is present. They are best taken in the morning and middle of the day.—*Journal d' Hygiène*.

THE CARE OF THE HAIR.

To much emphasis cannot be laid on the fact that the hair should be cared for intelligently, appropriately and regularly. It should be cleaned in tepid water once every week, and once a month—presuming there be no disease like abundant dandruff or any other scalp trouble—with a very mild solution of some simple alkaline substance like borax or bicarbonate of soda.

It is always better to wash the scalp and hair before retiring, as the opportunity for drying it is better, especially if the hair is thick or heavy, and there is less likelihood

of taking cold. Many of the finest suits of hair we have ever seen have been preserved and kept beautiful by the simple use of tepid or cool (not icy) water, the year round at morning toilet. As with everything else so with the hair, good judgment must be the guide. The fine comb, as an article of use for the hair, should never be thought of; the centre of a hot fire is the place for a fine comb, A good brush is the great tonic for the hair.

DRESSING THE HAIR.

Some writers utterly prohibit the use of oil or grease on the hair; others unduly magnify the advantages of its constant applications; but between abstinence and unlimited use is the true plan. Some hair is harsh and dry, do for it what you will; such hair requires the occasional application of oil; other hair is always oily and "just right;" for the latter very little "dressing is required."

PRESERVING THE HAIR.

To keep a "heavy head of hair" is the desire and delight of every one. The law of heredity excepted, there is no reason or cause why so many should be bald or have thin or "patchy" hair. Carefully attending to the hair, having it trimmed at regular intervals, keeping the scalp clean, never allowing a barber to use other than your own brush and comb in arranging your hair, avoiding the constant wearing of a hat—these are all contributing influences towards the preservation of the hair "e'en down to old age" and the grave.

NEWS AND MISCELLANY.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY FROM OCTOBER 23, 1892, TO OCTOBER 29, 1892.

Captain Freeman V. Walker, Assistant Surgeon, U. S. Army, granted leave of absence for one month, to take effect on arrival of 1st Lieut. George D. De Shon, Assistant Surgeon, U. S. Army, at Fort D. A. Russell, Wyoming.